Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37001

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): BLANCHE CORNELIA KENNEDY
2. Dete of Deeth: Month 11 Dey 16 Yeer 98
3. Time of Deeth: 7:15AM
4e. Fecility Neme (If not institution, give street and number): CORSICA HILL NURSING CENTER
4b. City, Town, or Location of Death: CENTREVILLE
4c. County of Deeth: QUEEN ANNE'S

Funeral Director

5. Social Security Number: 150-07
6. Sex: 1☐M 2☑F
7. Age (In yrs. lest birthday): 93 Yrs. | If Under 1 Yeer: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Dey, Yeer): 01-20-1905
9. Birthplace (Stete or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: QUEEN ANNE'S
10c. City, Town or Location: CENTREVILLE
10d. Inside City Limits: 1☐Yes 2☑No
10e. Street end Number: 1522 BURRISVILLE RD
10f. Zip Code: 21617
10g. Citizen of Whet Country?: USA

11. Meritel Status: 1☑Never Married 2☐Married 3☐Widowed 4☐Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐Yes 2☐No If Yes, Give Year or Dates:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.): 1☐Yes 2☑No Specify:
14. Race - American Indien, Black, White, etc. Specify: BLACK

15. Decedent's Eduction (Specify only highest grede completed): Elementary/Secondary (0-12): 10TH | College (1-4or 5+):
16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): HOUSEKEEPER
16b. Kind of Business/Industry: DOMESTIC

17. Father's Neme (First, Middle, Last): JEREMIAH KENNEDY
18. Mother's Neme (First, Middle, Meiden Surneme): ANNIE WILSON

19a. Informent's Name/Relationship (Type, Print): MRS. RUTH MOORE · SISTER
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 1522 BURRISVILLE RD. CENTREVILLE, MD 21617

20a. Method of Disposition: 1☑Burial 2☐Cremetion 3☐Removel from State 4☐Donetion 5☐Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): MALE/FEMALE BENEFICAL LODGE
Dete: 11-19-98
20c. Location - City or Town, State: BURRISVILLE, MD

21. Signeture of Funerel Service Licensee: Joyce O. Walley
22. Neme end Address of Fecility: WALLEY FUNERAL HOME CHESTERTOWN, MD 21620

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complicetions that ceused the deth. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heert failure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Death

Immediate Ceuse (Finel disease or condition resulting in death): e. Pancreatic CA — 1M

Due to (or es e consequence of): Jaundice

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in deeth) Lest:
b. Due to (or es e consequence of):
c. Due to (or es e consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐Yes 2☑No 3☐Probably 4☐Unknown

24a. Wes en eutopsy performed? 1☐Yes 2☑No
24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? 1☐Yes 2☐No

25. Wes case referred to medical examiner? 1☐Yes 2☑No

26. Place of Deeth (Check only one): Hospital: 1☐Inpetient 2☐ER/Outpetient 3☐DOA Other: 4☑Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Deeth: 1☑Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Dete of Injury (Month, Dey Yeer)
28b. Time of Injury M
28c. Injury et Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑**Certifying Physicien:** To the best of my knowledge, death occurred at the time, dete end plece, end due to the ceuse(s) end manner es steted. 2☐**Medical Exeminer:** On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) end manner steted.

29b. Signeture end title of certifier:
29c. License number: D32036
29d. Date signed (Month, Dey, Yeer): 11/19/98

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): DR. GARY SPROUSE. 2108 APPLE PLZ · CHESTER, MD 21619

State Registrar

31. Date filed (Month, Day, Year): NOV 20 1998
32. Registrar's Signeture: Geneva G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mentel Hygiene. **Important: If item 27 is marked other than "natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37002

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: GEORGE A KELLER

2. Date of Death Month Day Yaer: NOVEMBER 8, 1998

3. Tima of Death: 4:30 AM

4e Fecility Nama *(If not institution, giva street end number)*: THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE CITY

4c. County of Deeth:

Funeral Director

5. Social Security Number: 455-24-0742

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. lest birthday)*: 74 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Dey, Yeer)*: 9-25-24

9. Birthplece *(Stete or Foreign Country)*: TEXAS

Usuel Residence of Decedent

10a. Stata: PA

10b. County: FRANKLIN

10c. City, Town or Location: GREENE TWP.

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 32 KENSINGTON DR.

10f. Zip Code: 17201

10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1☐ Nevar Marriad 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedant Evar in U.S. Armed Forces? 1☒ Yas 2☐ No If Yes, Give Yaar or Dates:

13. Wes Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - Americen Indian, Bleck, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): / College (1-4or 5+): 4

16a. Decedent's Usuel Occupation *(Giva kind of work done during most of working life. DO NOT use retired)*: CAREER ARMY OFFICER US GOV'T.

16b. Kind of Business/Industry: DEFENCE

17. Fathar's Name *(First, Middla, Last)*: GEORGE A. KELLER SR.

18. Mother's Nama *(First, Middle, Maiden Surneme)*: FELIX GARDNER

19a. Informent's Neme/Reletionship *(Type, Print)*: JOAN KELLER (WIFE)

19b. Mailing Address *(Street and Number or Rurel Route Number, City or Town, State, Zip Code)*: 32 KENSINGTON DR. CHAMBG. PA 17201

20a. Method of Disposition: 1☐ Buriel 2☒ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Place of Disposition *(Nema of cemetery, cremetory or other piece)*: SMITHSBURG CREMATORY

Date: 11-10-98

20c. Location - City or Town, State: SMITHSBURG MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Fecility: 11824 Reisterstown Road ELINE FUNERAL HOME Reisterstown, Md. 21136

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that causad tha daath. Do not antar the mode of dying, such as cardiac or raspiratory arrast, shock, or heart feilure. List only one cause on each line.

Approximete Intervel Between Onset end Death

Immediate Ceuse (Finel disease or condition resulting in deeth)

e. Coronary Artery Disease — Years

Due to (or as e consequence of):

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initieted events rasulting in deeth) Lest

b. Aortic Stenosis — Years

Dua to (or as a consequence of):

c. Mitral Regurgitation — Years

Due to (or es e consequence of):

d.

Pert II. **Other significent conditions** contributing to death but not resulting in the underlying causa given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Was en eutopsy performed? 1☒ Yes 2☐ No

24b. Were eutopsy findings available prior to complation of cause of deeth? 1☐ Yes 2☒ No

25. Was cese refarred to medical exeminer? 1☐ Yes 2☒ No

26. Plece of Deeth *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Plece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end piece, end due to the ceuse(s) end menner es steted. 2☐ **Medicel Examiner:** On the besis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) end menner stated.

29b. Signature end title of certifier: [signature]

29c. License number: RES 000

29d. Data signad *(Month, Dey, Yeer)*: 11/8/98

30. Name end address of person who completed ceuse of deeth (Item 23e) (Type, Print): PIROOZ EGHTESADY - 600 N. Wolfe St.

State Registrar

31. Date filed *(Month, Dey, Yeer)*: NOV 12 1998

32. Registrar's Signature: Penina G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37003

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Henry Lawrence LAKE, SR.

2. Date of Death: Month November Day 18 Year 1998

3. Time of Death: 4:23 P.M.

4a. Facility Name (If not institution, give street and number): 8208 Pembrook Court

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 217-28-0782

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 66 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 14, 1932

9. Birthplace (State or Foreign Country): Maryland

Usuet Residence of Decedent

10a. Stete: Maryland

10b. County: Frederick

10c. City, Town or Location: Frederick

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street end Number: 8208 Pembrook Court

10f. Zip Code: 21704

10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1952

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Raca - American Indian, Bteck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 10 | College (1-4or 5+):

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Laborer

16b. Kind of Business/Industry: Cement Company

17. Fether's Name (First, Middle, Last): William C. LAKE

18. Mother's Name (First, Middle, Maiden Sumeme): Arttie M. SYLVUS

19a. Informent's Name/Relationship (Type, Print): Caroline E. Lake, Wife

19b. Maiting Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8208 Pembrook Court, Frederick, MD 21704

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Piece of Disposition (Name of cemetery, crematory or other piece): Mount Olivet Cemetery, Date: Nov. 21, 1998

20c. Location - City or Town, State: Frederick, Maryland

21. Signature of Funeral Service Licensee: Allan H Ruby MO0703

22. Name end Address of Facility: Keeney & Basford P.A. Funeral Home, 106 East Church Street, Frederick, MD 21701

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heert failure. List only one ceuse on each line.

		Approximete Intervel Between Onset end Death
Immediate Ceuse (Final disease or condition resulting in death) e.	Non Small cell lung cancer	5m.
Due to (or es e consequence of): b.	metastatic cancer to brain	5 m.
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in death) Lest — Due to (or es e consequence of): c.		
Due to (or es e consequence of): d.		

Pert II. **Other eignificant conditions** contributing to death buf not resulting in the underlying cause given in Pert I.

23b. **Did tobacco use contribute to the cauee of death?** 1 [X] **Yes** 2 [ ] **No** 3 [ ] **Probably** 4 [ ] **Unknown**

24a. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical exeminer? 1 [ ] Yes 2 [X] No

26. Plece of Deeth (Check only one): Hospitel: 1 [ ] tnpatient 2 [ ] ER/Outpetient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Deeth: 1 [X] Naturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury et Work? 1 [ ] Yes 2 [ ] No

28d. Describe how Injury occurred

28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Phyeicien**: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner es steted. 2 [ ] **Medical Examiner**: On the basis of examinetion and/or Investigation, tn my opinion, deeth occurred et the time, date and placa, end due to the cause(s) end menner stated.

29b. Signeture end titte of certifier: [signature] MD

29c. License number: D 48184

29d. Date signed (Month, Day, Year): Nov 19, 1998

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print): Elhamy D. Eskander, MD 501 W 7th Street Frederick MD 21701

State Registrar

31. Dete filed (Month, Day, Year): NOV 20 1998

32. Registrar's Signeture: [signature] G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours eftar death with tha Maryland Dapartmant of Haalth and Mantal Hygiana. **Important: If item 27 is marked other than "natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: Tha law raquires that tha daath certificata be executed within 24 hours aftar daath.
To the Funeral Director: Aftar this cartificata has baan signed by the attending physician and completely filled in by tha funaral director, paga 2 should be datached for usa as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEM #20b PER FH G774 8/26/99 AH

Certificate of Death

Reg. No. 98 37004

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
ELSIE	*Simmons*	LONG	NOVEMBER	13,	1998	8:15 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Frederick Memorial Hospital	Frederick	Frederick

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
227-03-8080	1☐ M 2☒ F	85 Yrs.					Apr. 14, 1913	Virginia

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Frederick	Frederick	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
30 North Place	21702	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10		Dog Groomer	Self-employed

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Meiden Surname)
Luther Simmons	Viola Fridley

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Barbara Horner - Granddaughter	2306 Oak Drive, Ijamsville, Maryland 21754

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other piece)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Allegheny Memorial Park	11/16/98	Covington, Virginia

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Facility: Stauffer Funeral Homes, P. A.
1621 Opossumtown Pike, Frederick, Maryland 21702

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ACUTE MYOCARDIAL INFARCTION	3 DAYS
Due to (or as a consequence of):	b. EMPHYSEMA	10 YRS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	
Due to (or as a consequence of):	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Wes en eutopsy performed?	24b. Were autopsy findings available prior to completion of ceuse of death?
1☐ Yes 2☑ No	1☐ Yes 2☐ No

25. Was cese referred to medical examiner?	26. Piece of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end menner es steted.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) and manner stated.

29b. Signeture and title of certifier	29c. License number	29d. Date signed (Month, Dey, Yeer)
▶ [signature] MD	D47611	11-13-98

30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print)
NEIL WARADPRIUM MD 1475 TANEY AVE #204 FREDERICK MD 21702

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 19 1998	▶ [signature]

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Merylend Department of Health end Mental Hygiene. **Important: If item 27 is marked other than "natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funerel director, page 2 should be detached for use es the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37005

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Madeline P. Lawton

2. Date of Death Month / Day / Year: November 6 1998

3. Time of Death: 10:00am

4a. Facility Name *(If not institution, give street and number)*: Shady Grove Nursing Home and Rehabilitation

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 046-16-7109

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 74 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Sept. 17, 1924

9. Birthplace *(State or Foreign Country)*: Connecticut

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Rockville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 12924 Circle Drive

10f. Zip Code: 20850

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Payroll Administrator

16b. Kind of Business/Industry: City of Ann Arbor, Michigan

17. Father's Name *(First, Middle, Last)*: Donato Pepe

18. Mother's Name *(First, Middle, Maiden Surname)*: Vera Bartolini

19a. Informant's Name/Relationship *(Type, Print)*: Russell Lawton/ Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 12924 Circle Drive, Rockville, Maryland 20850

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Bethlehem Cemetery

Date: 11/14/98

20c. Location - City or Town, State: Ann Arbor, Michigan

21. Signature of Funeral Service Licensee: Todd D Wynn

22. Name and Address of Facility: Olin L. Molesworth P. A. Funeral Home 26401 Ridge Road, Damascus, Maryland 20872

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Non Hodgkins Lymphoma — 20 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Joseph Kaplan

29c. License number: D35635

29d. Date signed *(Month, Day, Year)*: November 9, 1998

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Joseph Kaplan, M.D. 18111 Prince Philip Drive, Olney, Maryland 20832

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 10 1998

32. Registrar's Signature: Deanna B. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37006

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John Leskiw

2. Date of Death (Month, Day, Year): November 15 1998

3. Time of Death: 1536

4a. Facility Name (If not institution, give street and number): Union Hospital

4b. City, Town, or Location of Death: Elkton

4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 221-20-0661

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 79 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 2, 1919

9. Birthplace (State or Foreign Country): Ukraine

Usual Residence of Decedent

10a. State: De.

10b. County: New Castle

10c. City, Town or Location: Newark

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 652 W. Chestnut Hill Rd.

10f. Zip Code: 19713

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. White Specify:

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 / College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Sales

16b. Kind of Business/Industry: Retail Liquor

17. Father's Name (First, Middle, Last): Wasyl Leskiw

18. Mother's Name (First, Middle, Maiden Surname): Anna

19a. Informant's Name/Relationship (Type, Print): Sonia S. Leskiw, Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 652 W. Chestnut Hill Rd., Newark, De. 19713

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): All Saints Cemetery

Date: 11/19/98

20c. Location - City or Town, State: Wilm., De.

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: 259 E. Main St., Gee Funeral Home Elkton, Md. 21921

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. AORTIC INSUFFICIENCY — UNKNOWN

Due to (or as a consequence of):

b. AORTIC ANEURYSM

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CORONARY ARTERY DISEASE

ATRIAL FIBRILLATION

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D28409

29d. Date signed (Month, Day, Year): 11/19/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): EHSANUR RAHMAN MD SUITE 131, 4745 OGLETOWN STANTON RD. NEWARK, DE. 19713

State Registrar

31. Date filed (Month, Day, Year): NOV 19 1998

32. Registrar's Signature: [signature]

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Leskiw, John

10

DHMH 16 Rev 6/95

ok GAP

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37007

Lapole, Nellie Jane

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Nellie Jane Elizabeth Lapole
2. Date of Death: Month November Day 20 Year 1998
3. Time of Death: 9:05 PM
4a. Facility Name (If not institution, give street and number): Reeders Memorial Home
4b. City, Town, or Location of Death: Boonsboro
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 241-28-7360
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 4, 1914
9. Birthplace (State or Foreign Country): South Carolina

Usual Residence of Decedent

10a. State: Maryland
10b. County: Washington
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 11 South Walnut St.
10f. Zip Code: 21740
10g. Citizen of Whet Country?: USA

11. Maritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Rece - American Indian, Black, White, etc. Specify: White

15. Decedent's Educetion (Specify only highest grade completed): Elementary/Secondary (0-12): 6 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cook
16b. Kind of Business/Industry: Medical

17. Father's Neme (First, Middle, Last): Charles Hall
18. Mother's Neme (First, Middle, Maiden Surneme): Polly Ann Gregory

19a. Informent's Neme/Relationship (Type, Print): Dorothy L. Gerberich/daughter
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 11 W.Baltimore St. Hagerstown,MD 21740

20a. Method of Disposition: 1☒ Buriel 2☐ Cremation 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Name of cemetery, cremetory or other piece): Rose Hill Cemetery | Date: Nov.24,1998
20c. Location - City or Town, State: Hagerstown,Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name end Address of Facility: Osborne Funeral Home 425 S. Conococheague St. Williamsport,MD 21795

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heart failure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Deeth

Immediete Ceuse (Finel diseese or condition resulting in death)
e. STROKE — 3 WKS

Due to (or as e consequence of):
b. ATHROSCLEROSIS — YEARS

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury thet initiated events resulting in deeth) Lest
Due to (or es e consequence of):
c. SENILITY

Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
ANOREXIA
DEPRESSION

23b. Did tobecco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an eutopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical exeminer? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours efter death.
To the Funeral Director: After this certificate has been signed by the ettending physician end completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

29a. Certifier (Check only one): 1☒ **Certifying Phyeician:** To the best of my knowledge, death occurred et the time, dete end piece, end due to the ceuse(s) and menner es steted. 2☐ **Medical Examiner:** On the besis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date and place, end due to the cause(s) end menner steted.

29b. Signeture end title of certifier: [signature]
29c. License number: D44996
29d. Dete signed (Month, Dey, Year): NOV 21, 1998

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print): Dr Zafar Malik 20311 Lappans road Boonsboro, Maryland 21713

State Registrar

31. Dete filed (Month, Day, Year): NOV 23 1998
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEM#20a PER FH G774 8/26/99 AH

Certificate of Death

Reg. No. 98 37008

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Dete of Death Month / Day / Year	3. Time of Death
Hallie	Rebecca	McLaren	November 20, 1998	11:50 A.M.

4e Facility Name (If not institution, give street end number)	4b. City, Town, or Location of Deeth	4c. County of Deeth
Northampton Manor Nursing Home	Frederick	Frederick

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. lest birthday)	If Under 1 Yeer: Months / Deys	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Dey, Yeer)	9. Birthplece (Stete or Foreign Country)
220-40-2414	1☐ M 2☒ F	85 Yrs.			October 14,13	Maryland

Usuel Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Frederick	Frederick	1☑ Yes 2☐ No

10e. Street end Number	10f. Zip Code	10g. Citizen of Whet Country?
2635 Warren Way	21701	United States

11. Marital Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Merried 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Yeer or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grede completed)		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8		School Bus Driver	County School

17. Fether's Name (First, Middle, Last)			18. Mother's Name (First, Middle, Meiden Surneme)	
Reuben	Hollis	Koontz	Mary	Buckman

19a. Informant's Name/Reletionship (Type, Print)	19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code)
Robert E. Baltzell/ son	9434 Woodsboro Pike / Walkersville, Md. 21793

20a. Method of Disposition	20b. Piece of Disposition (Name of cemetery, cremetory or other placa)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)	Resthaven Memorial Gardn.	11-23-98	Frederick, Maryland

21. Signeture of Funerel Servica Licansee: Raymond Peterson

22. Name end Address of Facility: Stauffer Funeral Home, 1621 Opossumtown Pike/ Frederick, Md. 21702

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Final diseese or condition resulting in death)	e. Acute Cerebral Vescular Accident (Stroke)	24 hours.
	Due to (or es e consequence of):	
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest	b. Severe Dementia	
	Due to (or es e consequence of):	
	c.	
	Due to (or es e consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed?	24b. Were eutopsy findings eveilable prior to completion of cause of deeth?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical exeminer?	26. Place of Death (Check only one)	
1☐ Yes 2☑ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Deeth	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify)	28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end piece, end due to the ceuse(s) end menner es stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, In my opinion, death occurred et the time, dete end place, end due to the ceuse(s) end menner steted.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Yeer)
Gerard Delgrippo	D 41994	November 20, 1998

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print): Gerard Delgrippo, Frederick St./ Walkersville, Md. 21793

State Registrar

31. Date filed (Month, Dey, Yeer): NOV 23 1998

32. Registrar's Signeture: Geneva G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Merylend Department of Health end Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the deeth certificate be executed within 24 hours eftar death. **To the Funeral Director:** After this certificata has been signed by the ettanding physician end completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37009

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Blanche Harriet MICHAEL

2. Date of Death Month Day Yeer: November 19, 1998

3. Time of Death: 2:30 p.m.

4a. Facility Neme *(If not institution, give street and number)*: 216 Lindburgh Avenue

4b. City, Town, or Location of Death: Frederick

4c. County of Deeth: Frederick

Funeral Director

5. Social Security Number: 213-74-5165

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. lest birthday)*: 98 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Dey, Year)*: August 21, 1900

9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usuel Residenca of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Frederick

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 216 Lindburgh Avenue

10f. Zip Code: 21701

10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grede completed)*: Elementary/Secondary (0-12): | College (1-4or 5+): 2

16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Justus B. Atkinson

18. Mother's Neme *(First, Middle, Maiden Surname)*: Mary Elizabeth Rhinehart

19e. Informent's Name/Reletionship *(Type, Print)*: Margery Sigler/Niece

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 1609 West Seventh Street, Frederick, MD 21702

20e. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removel from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*: Mt. Olivet Cemetery

Dete: Nov. 23, 1998

20c. Location - City or Town, Stete: Frederick, Maryland

21. Signeture of Funeral Service Licensee: Richard C. Basford MO0021

22. Neme end Address of Facility: Keeney and Basford Funeral Home 106 East Church Street, Frederick, MD 21701

Physician /Medical Examiner

23a. Pert I. Enter the diseese, or complicetions thet caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset end Death

Immediete Cause (Final disease or condition resulting in death)
e. Gastrointestinal bleed — 24 hrs

Due to (or as a consequence of):
b. Hiatus Hernia — Many year)

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury thet Initieted events resulting in deeth) Lest

Due to (or es e consequence of):
c.

Due to (or es a consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

Kidney tumor
hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Dete of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Plece of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the besis of exemination end/or Investigetion, in my opinion, death occurred et the time, date end plece, end due to the ceuse(s) end manner stated.

29b. Signeture end title of certifier: Austin Pearre D.

29c. License number: D09689

29d. Date signed *(Month, Dey, Year)*: 11/23/98

30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print): A.A. PEARRE, M.D. 300 W. 9th St. FREDERICK, MD. 21701

State Registrar

31. Dete filed *(Month, Day, Year)*: NOV 23 1998

32. Registrar's Signature: Penne B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificete be executed within 24 hours efter death.
To the Funerel Director: After this certificete has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEMS 23a part I & II PER MD G774 8/26/99 AH

Certificate of Death

Reg. No. 98 37010

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WILLIAM AUSTIN MULLICAN

2. Date of Death: Month November Day 14 Year 1998

3. Time of Death: 6:35AM

4a Facility Name (If not institution, give street and number): Frederick Memorial Hospital

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 214-10-3329

6. Sex: ☒ M ☐ F

7. Age (In yrs. last birthday): 82 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb. 29, 1916

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Frederick

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 9547 Liberty Road

10f. Zip Code: 21701

10g. Citizen of What Country? United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 9th

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Grad-All Operator

16b. Kind of Business/Industry: County Highway Dept.

17. Father's Name (First, Middle, Last): William Thomas Mullican

18. Mother's Name (First, Middle, Maiden Surname): Emma Irene Nusbaum

19a. Informent's Name/Reletionship (Type, Print): Margaret Mullican, wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9547 Liberty Road Frederick, Maryland 21701

20a. Method of Disposition: 1 ☒ Buriel 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify)

20b. Piece of Disposition (Name of cemetery, crematory or other place): Union Chapel Cemetery

Date: 11/17/98

20c. Location - City or Town, State: Libertytown, Maryland

21. Signature of Funeral Service Licensee

22. Name end Address of Facility: Stauffer Funeral Homes, P.A.

1621 Opossumtown Pike Frederick, Maryland 21702

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset end Deeth

Immediate Cause (Final disease or condition resulting in death)

e. ~~ACUTE RENAL FAILURE~~ ACUTE PERITONITIS — ~~3 DAYS~~ 1month

Due to (or es e consequence of):

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury thet initiated events resulting in deeth) Lest

b. CLOSTRIDIUM DIFFICILE ENTERITIS — 1month

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

ACUTE CONGESTIVE HEART FAILURE

CEREBROVASCULAR ACCIDENT RENAL FAILURE

~~TOXIC MEGACOLON (C. DIFFICILE) & RUPTURE~~

ACUTE MYOCARDIAL INFARCTION

23b. Did tobacco use contribute to the cauee of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Wes en eutopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one) Hospitel: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Deeth: 1 ☒ Naturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury et Work? 1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 ☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner es steted. 2 ☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) end manner stated.

29b. Signature and title of certifier: MD

29c. License number: D32171

29d. Date signed (Month, Day, Year): 11/16/98

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

R. GOUGH PO Box 328 WALKERSVILLE MD 21793

State Registrar

31. Dete filed (Month, Day, Year): NOV 16 1998

32. Registrer's Signeture

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

Please Type or Print in Black indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37011

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ALVIN B. MCSPADDEN

2. Date of Death (Month, Day, Year): November 11, 1998

3. Time of Death: 4:55pm

4a. Facility Name (If not institution, give street and number): Citizens Nursing Home

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 432-48-2010

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 79 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 4, 1919

9. Birthplace (State or Foreign Country): Arkansas

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Frederick

10d. Inside City Limits: 1 [ ] Yes [X] No

10e. Street and Number: 5515 Feagaville Lane

10f. Zip Code: 21702

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Carpenter

16b. Kind of Business/Industry: Building

17. Father's Name (First, Middle, Last): George W. McSpadden

18. Mother's Name (First, Middle, Maiden Surname): Hattie Love

19a. Informant's Name/Relationship (Type, Print): Brenda M. Edwards, daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 160 Willowdale Drive Apt. G-103 Frederick, MD 21702

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): St Lukes Cemetery

Date: 11/14/98

20c. Location - City or Town, State: Feagaville, Maryland

21. Signature of Funeral Service Licensee: Brad Peterson

22. Name and Address of Facility: Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, MD 21702

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final diseese or condition resulting in death): a. Cerebrovasc. Accident — 2 hrs

Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and piece, end due to the cause(s) and manner es steted. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: Ronald L. Kaufman

29c. License number: D13971

29d. Date signed (Month, Day, Year): 11/16/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 300 W. 9th St. Frederick MD 21701

State Registrar

31. Date filed (Month, Day, Year): NOV 16 1998

32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37012

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William B. Minnick, Sr.

2. Date of Death (Month, Day, Year): November 10, 1998

3. Time of Death: 3:03am

4a. Facility Name (If not institution, give street and number): SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death: ROCKVILLE

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 577-42-1293

6. Sex: 1☒M 2☐F

7. Age (In yrs. last birthday): 68 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): October 2,1930

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Carroll

10c. City, Town or Location: Mt. Airy

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 4617 Old National Pike

10f. Zip Code: 21771

10g. Citizen of What Country?: United States

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates: Korean

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elamantary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Supervisor

16b. Kind of Business/Industry: Federal Government

17. Father's Name (First, Middle, Last): Carl Rudolph Minnick

18. Mother's Name (First, Middle, Maiden Surname): Edna Marie Armentrout

19a. Informant's Name/Relationship (Type, Print): Ann Kontner/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4820 Marianne Drive, Mt. Airy, Maryland 21771

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematorium | Date: Incl1/12

20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: Todd D Wynn

22. Name and Address of Facility: Olin L. Molesworth P. A. Funeral Home 26401 Ridge Road, Damascus, Maryland 20872

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CONGESTIVE HEART FAILURE — 4 WEEKS.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: PNEUMONIA

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and mannar as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at tha time, data and place, and due to the cause(s) and manner stated.

29b. Signeture end title of certifier: , M.D.

29c. License number: D35941

29d. Date signed (Month, Day, Year): NOVEMBER 10, 1998

30. Name end address of person who completed cause of death (Item 23a) (Type, Print): PURAN P. MATHUR, #401 50 W. EDMONSTON DR. ROCKVILLE, MD 20852.

State Registrar

31. Dete filed (Month, Day, Year): NOV 12 1998

32. Registrar's Signature: Geneva B. Sloan, I

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37013

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Irvin S. Martin, Sr.

2. Data of Death — Month: November Day: 6, Year: 1998

3. Time of Death: 2:43 PM

4a. Facility Name (If not institution, give street and number): Carroll County General Hospital

4b. City, Town, or Location of Death: Westminster

4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 214-16-1548

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 80 Yrs. — If Under 1 Year: Months / Days — If under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 20, 1918

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Carroll

10c. City, Town or Location: Mount Airy

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 3850 West Watersville Road

10f. Zip Code: 21771

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armad Forcas? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Educetion (Specify only highest grade completed) — Elementary/Secondary (0-12): 8 — College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Pastor - Electrical Contractor

16b. Kind of Business/Industry: Church - Electrical

17. Fathar's Nama (First, Middle, Last): Daniel W. Martin

18. Mother's Name (First, Middle, Maiden Surname): Rebecca Shank

19a. Informant's Name/Ralationship (Type, Print): Ruth M. Martin - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3850 West Watersville Road, Mount Airy, Maryland 21771

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Pine Grove Cemetery

Date: 11/10/98

20c. Location - City or Town, State: Mount Airy, Maryland

21. Signature of Funeral Sarvice Licensaa: Olin L. Molesworth

22. Nama and Address of Facility: Olin L. Molesworth P.A., Funeral Home, 26401 Ridge Road, Damascus, Maryland 20872-0117

Physician /Medical Examiner

23a. Part1. Enter tha disease, or compiications that ceusad tha daath. Do not entar tha moda of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on each line.

		Approximata Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Pulmonary Embolus	6 hours
Due to (or as a consequence of): b.	Deep Venous Thrombosis	4 weeks
Sequantially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last — Due to (or as a consequance of): c.	Chronic Lymphocytic leukemia	4 yrs
d.		

Part II. **Other significant conditiona** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobecco use contribute to the cause of death? 1 [ ] Yes 2 [✓] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of ceuse of death? 1 [ ] Yes 2 [ ] No

25. Was cese referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death (Check only one) — Hospital: 1 [ ] Inpatient 2 [✓] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] **Certifying Phyaician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medicel Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piace, and due to the causa(s) and manner stated.

29b. Signatura and title of certifier: JULIO MENOCAL

29c. License number: D 31912

29d. Date signed (Month, Day, Year): 11/07/98

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): 1564 Opossumdown Pike FREDERICK MD 21702.

State Registrar

31. Date filed (Month, Day, Year): NOV 10 1998

32. Registrar's Signature: [illegible] B. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with tha Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attanding Physician: Tha law requires that tha death certificata be axecuted within 24 hours aftar death.
To the Funeral Director: Attar this certificate has baan signed by tha attanding physician and completely filled in by tha funaral director, page 2 should be datached for usa as tha burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37014

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
Ella	Margaret	McCONNELL	November 5, 1998	4:20 pm

4a Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Citizens Nursing Home of Frederick County	Frederick	Frederick

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
114-24-2843	1☐ M 2☒ F	101 Yrs.			Sep 2, 1897	New York

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Frederick	Frederick	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1900 Rosemont Avneue	21702	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4 or 5+)		
	2	Homemaker	Own Home

17. Father's Name (First, Middle, Last)			18. Mother's Name (First, Middle, Maiden Surname)	
John	Jason	CONDON	Sarah	PRITCHARD

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Franklin J. McConnell/Son	8904 Barn Owl Court, New Port Richey, FL 34654

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Smithsburg Crematory	Nov 6, 1998	Smithsburg, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Kathryn Boerger	Keeney & Basford P.A. Funeral Home 106 E Church Street, Frederick, Maryland 21701

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Right Hip Fracture	3 weeks
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒ Yes 2☐ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined	Oct 12, 1998	9:30a M	1☐ Yes 2☒ No	Fell while walking

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
At home (Nursing Facility)	355 Montevue Lane Frederick, Maryland 21702

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Andrew Zarick, Jr.	D35164	November 06, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Andrew Zarick, Jr, M.D., 1080 West Patrick Street, Frederick, Maryland 21703

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 09 1998	Geneva G. Spare

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37015

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: THELMA VIRGINIA MORRIS

2. Date of Death — Month: November; Day: 22; Year: 1998

3. Time of Death: 9:00 A.M.

4a. Facility Name *(If not institution, give street and number)*: Memorial Hospital & Medical Center

4b. City, Town, or Location of Death: Cumberland

4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 213-64-8890

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 76 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: FEB 1 1922

9. Birthplace *(State or Foreign Country)*: W.VA.

Usual Residence of Decedent

10e. State: MARYLAND

10b. County: ALLEGANY

10c. City, Town or Location: LAVALE

10d. Inside City Limits: 1☐ Yes 2☒ No XX

10e. Street and Number: 10701 GREENPOINT ROAD N.W.

10f. Zip Code: 21502

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married XX 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates: X

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No X Specify:

14. Race - Americen Indian, Black, White, etc. Specify: WHITE

15. Decedent's Educetion *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 9; College (1-4or 5+):

16e. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOUSE WIFE

16b. Kind of Business/Industry: HOUSE WIFE

17. Fether's Neme *(First, Middle, Last)*: PAGE PAXTON

18. Mother's Name *(First, Middle, Maiden Surneme)*: DELLA TETER

19a. Informant's Name/Relationship *(Type, Print)*: ULYSSES (JOHN) MORRIS

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: HUSBAND 10701 GREENPOINT ROAD N.W. LAVALE MARYLAND 21502

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*: PROSPERITY CEMETERY

Dete: NOV 25 1998

20c. Location - City or Town, Stete: CHANEYSVILLE PA.

21. Signature of Funeral Service Licensee: Dale L. Merritt

22. Name and Address of Facility: MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND

Physician /Medical Examiner

23a. Pert I. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on eech line.

		Approximete Interval Between Onset end Death
Immediate Ceuse (Finel disease or condition resulting in deeth) a.	ANOXIC ENCEPHALOPATHY	5 DAYS
Due to (or es e consequence of):		
b.	VENTRICULAR FIBRILLATION	5 DAYS
Due to (or es e consequence of):		
Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Last c.		
Due to (or es e consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.: MITRAL REGURGITATION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Piece of Death *(Check only one)*: Hospitel: 1☒ Inpetient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Yeer)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) end menner es steted. 2☐ **Medicel Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end manner stated.

29b. Signature end title of certifier: M.D

29c. License number: 23334-D

29d. Dete signed *(Month, Dey, Year)*: November 24th 1998

30. Neme end eddress of person who completed ceuse of death (Item 23e) (Type, Print): DR. DINESH SHAH 625 KENT AVE. CUMBERLAND MARYLAND

State Registrar

31. Dete filed *(Month, Day, Year)*: NOV 24 1998

32. Registrer's Signature: Patricia D. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

THELMA MORRIS 213-64-8890

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

3

NS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37016

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): JAMES B. MESSICK

2. Dete of Deeth: Month November Dey 14 Yeer 1998

3. Time of Deeth: 1703

4e Fecility Neme (If not institution, give street end number): PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Deeth: SALISBURY

4c. County of Deeth: WICOMICO

Funeral Director

5. Sociel Security Number: 214-32-6007

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. lest birthdey): 64 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Yeer): August 9, 1934

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Wicomico

10c. City, Town or Location: Fruitland

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: #1 BohnaK Trailer Park

10f. Zip Code: 21826

10g. Citizen of Whet Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Detes: Army

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9; College (1-4or 5+): -

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Line Worker

16b. Kind of Business/Industry: Bottling Co.

17. Fether's Name (First, Middle, Last): James B. Messick

18. Mother's Name (First, Middle, Meiden Surname): Elsie Reddish

19a. Informant's Name/Reletionship (Type, Print): Jay Allen Messick/Brother

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): P.O. Box 202, Fruitland, MD 21826

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, crematory or other place): Springhill Memory Gardens

Date: 11/18/98

20c. Location - City or Town, Stete: Hebron, MD

21. Signeture of Funerel Service Licensee:

22. Neme end Address of Facility: Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complicetions that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failure. List only one ceuse on each line.

Approximete Interval Between Onset end Death

Immediate Cause (Finel disease or condition resulting in deeth): e. Acute GI Bleed — 24 hours

Due to (or es e consequence of):

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in death) Lest:

b.

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

Lung Mass

Cardiomyopathy

COPD

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was cese referred to medical examiner? 1☐ Yes 2☒ No

26. Piece of Deeth (Check only one): Hospital: 1☒ Inpetient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Yeer)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physicien:** To the best of my knowledge, deet occurred et the time, dete and place, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the besis of exemineticn end/or i gation, in my opinion, deeth occurred et the time, date end piece, end due to the cause(s) end manner stated.

29b. Signeture end title of certifier: D.O.

29c. License number: H50467

29d. Date signed (Month, Dey, Yeer): 11/15/98

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): Chris Snyder D.O. 108 Pine Bluff Rd Salisbury MD 21801

State Registrar

31. Date filed (Month, Day, Year): NOV 18 1998

32. Registrer's Signeture: Geneva G Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires thet the death certificete be executed within 24 hours efter deeth.

To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use es the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

214-32-6007

James Messick

3+1VA

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37017

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death (Month / Day / Year)	3. Time of Death
HAROLD	HUDSON	MASON	November 13, 1998	0942

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
PENINSULA REGIONAL MEDICAL CENTER	SALISBURY	WICOMICO

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	If Under 1 Year: Days	If Under 24 Hrs.: Hours	If Under 24 Hrs.: Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
130-01-1808	1 [X] M 2 [ ] F	83 Yrs.					September 20, 1915	New York

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Wicomico	Salisbury	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
305 Brewington Drive	21801	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WW II	1 [ ] Yes 2 [X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4 or 5+)		
12	-	Postal Worker	U.S. Postal Service

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Harold Mason	Alice R. Hudson

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mary Ethel Mason/Wife	305 Brewington Dr., Salisbury, MD 21801

20a. Method of Disposition	20b. Place of Disposition (Name of cemetary, crematory or other place)	Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Wicomico Memorial Park	11/17/98	Salisbury, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ W R Dellinger LFSP	Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Hypertensive Atherosclerotic Cardiovascular Disease	4 years
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
Due to (or as a consequence of):		
	c.	
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Malignant Lymphoma

23b. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown	1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 [X] Yes 2 [ ] No	Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Allen W. Tustin, M.D.	D22996	Nov. 16, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Allen W. Tustin, M.D., 105 P. Ne Bluff Rd. Ste 7A, Salisbury, MD.

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 18 1998	▶ Denise G Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Harold Mason
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

6+1UA

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37010

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Vera May MARTIN
2. Date of Death Month Day Year: November 19, 1998
3. Time of Death: 5:00 PM
4a. Facility Name *(If not institution, give street and number)*: Dennett Road Manor Nursing Home
4b. City, Town, or Location of Death: Oakland
4c. County of Death: Garrett

Funeral Director

5. Social Security Number: 271-20-8044
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 76 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Dec. 13, 1921
9. Birthplace *(State or Foreign Country)*: Tennessee

Usual Residence of Decedent

10a. State: MD
10b. County: Garrett
10c. City, Town or Location: Oakland
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 109 Preston Lane
10f. Zip Code: 21550
10g. Citizen of Whet Country?: USA

11. Maritel Stetus: 1☐ Never Merried 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Evar in U,S. Armed Forces? 1☐ Yas 2☒ No If Yes, Give Year or Dates:
13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yas 2☒ No *Specify:*
14. Race - American Indien, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 7 | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Clerk
16b. Kind of Business/Industry: Drug Store

17. Fether's Neme *(First, Middle, Last)*: (Unknown) Miller
18. Mother's Nama *(First, Middle, Maiden Surname)*: (Unknown) (Unknown)

19a. Informent's Neme/Relationship *(Type, Print)*: Ray C. Martin, Nephew
19b. Mailing Address *(Street and Number or Rurel Route Number, City or Town, State, Zip Code)*: 54 Stanley Lane, Oakland, Maryland 21550

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removel from State 4☐ Donation 5☐ Other *(Specify)*
20b. Piece of Disposition *(Name of cemetery, crematory or other piece)*: Garrett Co. Mem. Gardens | Data: 11/22/98
20c. Location - City or Town, State: Oakland, MD

21. Signeture of Funeral Service Licensee: Bradley A. Stewart
22. Name and Address of Facility: Stewart Funeral Home 32 S. Second St., Oakland, MD 21550

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not anter tha mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on each line.

Approximete Intervel Between Onset and Death

Immediate Ceuse (Finel disease or condition resulting in death): a. Lung cancer — 4 - 6 wk

Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury thet initiated avents resulting in death) Lest

b. metastatic brain tumor — 4-6 wk

Dua to (or as a consequance of):

c.

Dua to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobecco uee contribute to the cause of death?** 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Naturel 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Panding Investigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Day Yaar)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurrad
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Phyeicien:** To the best of my knowledge, death occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred et the time, dete end place, end due to the ceuse(s) end manner stated.

29b. Signeture and title of certifier: Donald R. Richter M.D.
29c. License number: D30035
29d. Date signed *(Month, Dey, Yeer)*: 11-19-98

30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print): Donald R. Richter, M.D. 1533 Memorial Dr. Oakland MD 21550

State Registrar

31. Date filed *(Month, Day, Yeer)*: NOV 20 1998
32. Registrer's Signeture: Geneva G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attanding Physician: Tha law requiras that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attanding physician and completely filled in by the funeral director, page 2 should be detached for usa as the burial-transit

2

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37019

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: EVA MILSTEAD
2. Dete of Deeth — Month: NOVEMBER Dey: 18 Yeer: 1998
3. Time of Deeth: 8:15PM
4a. Feciity Name *(If not institution, give street end number)*: 2530 SMOKEYS PLACE
4b. City, Town, or Location of Deeth: NANJEMOY
4c. County of Deeth: CHARLES

Funeral Director

5. Social Security Number: 218-38-5485
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 86 Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Dey, Yeer)*: January 3,1912
9. Birthplace *(Stete or Foreign Country)*: Maryland

Usuel Residence of Decedent

10a. State: Maryland
10b. County: Charles
10c. City, Town or Location: Nanjemoy
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Streel end Number: 2530 Smokey Place
10f. Zip Code: 20662
10g. Citizen of Whet Country?: U.S.A.

11. Maritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces?: 1☐ Yes 2☒ No If Yes, Give Yeer or Detes: X
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indien, Bieck, White, etc. *Specify:* Black
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12): 4 — College (1-4or 5+):
16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Her Home
17. Fether's Neme *(First, Middle, Last)*: Robert Gutrick
18. Mother's Neme *(First, Middle, Maiden Surneme)*: Bertie Smith
19a. Informent's Name/Reletionship *(Type, Print)*: Lorraine Taylor Daughter
19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 2560 Smokey Place, Nanjemoy, Md. 20662
20e. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other *(Specify)*
20b. Plece of Disposition *(Neme of cemetery, cremetory or other plece)*: Mount Hope Baptist Church
Date: November 21, 1998
20c. Location - City or Town, Stete: Nanjemoy, MAryland
21. Signature of Funeral Service Licensee: M00668
22. Neme and Address of Feciility: Williams Funeral Home, P.A. 4270 Hawthorne Rd., Indian Head, Md.20640

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications that ceused the deeth. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heert feilure. List only one cause on each line. — Approximete Intervel Between Onset end Deeth

Immediate Cause (Finel disease or condition resulting in death): e. BREAST CANCER

Due to (or es e consequence of):

Sequentielly iist conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury thet initiated events resulting in deeth) Lest

b. Due to (or es e consequence of):

c. Due fo (or es e consequence of):

d.

Part II. **Other elgnificent conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobecco use contribute to the cauee of deeth? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveilebie prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Was case referred to medicel exeminer? 1☐ Yes 2☒ No

26. Plece of Death *(Check only one)*: Hospitei: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Dete of Injury *(Month, Dey Yeer)*
28b. Time of Injury M
28c. injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, farm, streel, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physicien**: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end manner es stated. 2☐ **Medical Examiner**: On the besis of exemination end/or investigation, in my opinion, deeth occurred at the time, date end plece, end due to the ceuse(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D28352
29d. Dete signed *(Month, Dey, Yeer)*: NOVEMBER 19,1998

30. Neme end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print): KRISHAN MATHUR, MD., P.O. BOX 2729, LA PLATA, MD 20646

State Registrar

31. Date filed *(Month, Day, Yeer)*: NOV 23 1998
32. Registrer's Signeture:

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37020

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GRACE MEHLROSE
2. Date of Death (Month, Dey, Year): NOVEMBER 23 1998
3. Time of Death: 12:42 PM
4a. Facility Name (If not institution, give street and number): 2294 Imperial Court
4b. City, Town, or Location of Death: Waldorf
4c. County of Death: CHARLES

Funeral Director

5. Social Security Number: 075-12-1825
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Yeer): OCT 13 1921
9. Birthplace (State or Foraign Country): New York

Usual Residence of Decedent

10a. State: Maryland
10b. County: Charles
10c. City, Town or Location: Waldorf
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street end Number: 2294 Imperial Court
10f. Zip Code: 20602
10g. Citizen of Whet Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Housewife
16b. Kind of Business/Industry: Own Home

17. Fether's Name (First, Middle, Last): Charles Ricotta
18. Mother's Name (First, Middle, Meiden Surneme): Hattie Levy

19a. Informent's Name/Relationship (Type, Print): Robert Mehlrose Sr (Son)
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 1795 Maurice Ave East Meadow, New York 11554

20a. Method of Disposition: 1☐ Burial 2☐ Cremetion 3☒ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Frederick Funeral Home
Dete: 11-24-98
20c. Location - City or Town, Stete: Flushing, N.Y. 11358

21. Signature of Funeral Service Licensee: John H. Eberwein M00173
22. Name end Address of Facility: J.H. Eberwein Mortuary 4433 White Plsins La White Plains, MD 20695

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

		Approximete Interval Between Onset end Death
Immediate Ceuse (Finel disease or condition resulting in death) e.	Renal Failure	YF- 72 Hrs
Due to (or es e consequenca of):		
Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Lest b.	Metastatic Cancer	6 months
Due to (or es e consequence of):		
c.	Primary Lung Cancer and	6 months
Due to (or es e consequence of):		
d.	Chronic Lymphocytic Leukemia	18 months

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Pneumonia

Ascitis

23b. Did tobacco use contribute to the cauee of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Piece of Deeth (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residenca 6☐ Other (Specify)

27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Pleca of Injury - At home, ferm, street, factory, offica building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the cause(s) end menner es steted. 2☐ **Medical Examiner**: On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, date end pleca, end due to the ceuse(s) and menner steted.

29b. Signeture end title of certifier: [signature], MD
29c. License number: D35345
29d. Date signed (Month, Dey, Year): Nov 24, 1998

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): George Leon M.D. 2000 St Thomas Drive Waldorf, MD

State Registrar

31. Dete filed (Month, Day, Year): NOV 23 1998
32. Registrer's Signeture: Geneva G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene.
Important: If item 27 is marked other than "natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37021

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Lorraine McCardell McNeil

2. Dete of Deeth: Month November Day 16, Yeer 1998

3. Time of Deeth: 9:00 p.m.

4a Facility Name *(If not institution, give street end number)*: Residence: 710 Rowland Road

4b. City, Town, or Location of Deeth: Colora

4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 218-22-4378

6. Sex: 1☐M 2☒F

7. Age *(In yrs. lest birthday)*: 73 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Day, Year)*: May 19, 1925

9. Birthplece *(Stete or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Cecil

10c. City, Town or Location: Colora

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 710 Rowland Road

10f. Zip Code: 21917

10g. Citizen of Whet Country?: U.S.A.

11. Marital Stetus: 1☐Never Merried 2☒Married 3☐Widowed 4☐Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 1☐Yes 2☒No *Specify:*

14. Rece - Americen Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grede completed)*: Elementery/Secondary (0-12): Twelve Years; College (1-4or 5+): ----

16e. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Personal Residence

17. Father's Name *(First, Middle, Last)*: Ernest Bayard McCardell

18. Mother's Name *(First, Middle, Maiden Surneme)*: Lidie Louise Morrison

19a. Informent's Name/Relationship *(Type, Print)*: Richard J. McNeil, Sr. (Husband)

19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, State, Zip Code)*: 710 Rowland Road, Colora, Maryland 21917

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donetion 5☐Other *(Specify)*

20b. Piece of Disposition *(Name of cemetery, crematory or other piece)*: Harmony Chapel Cemetery

Date: 11/20/98

20c. Location - City or Town, State: Colora, Maryland

21. Signature of Funeral Service Licensee: ▶ Thomas M. Patterson, Sr.

22. Name end Address of Facility: Lee A. Patterson & Son Funeral Home, Perryville, Maryland 21903-0188

To Be Completed by Funeral Director

permit. Pages 1 end 2 should be filed within 72 hours after death with the Meryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one ceuse on eech line.

Approximate Intervel Between Onset end Deeth

Immediate Ceuse (Final disease or condition resulting in death)

a. - CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Due to (or es e consequence of):

b. - LUNG CANCER

Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☒Yes 2☐No 3☐Probably 4☐Unknown

24e. Wes en eutopsy performed? 1☐Yes 2☒No

24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? 1☐Yes 2☒No

25. Wes cese referred to medical exeminer? 1☐Yes 2☒No

26. Piece of Death *(Check only one)*: Hospital: 1☐Inpetient 2☐ER/Outpetient 3☐DOA; Other: 4☐Nursing Home 5☒Residence 6☐Other *(Specify)*

27. Manner of Deeth: 1☒Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Dete of Injury *(Month, Day Yeer)*

28b. Time of Injury M

28c. Injury et Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rurel Route Number, City or Town, Stete)*

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificete be executed within 24 hours after deeth.

To the Funeral Director: After this certificate has been signed by the ettending physician end completely filled in by the funerel director, page 2 should be detached for use es the burial-transit

29e. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, death occurred et the time, dete end piece, end due to the ceuse(s) end menner es stated. 2☐**Medical Examiner:** On the beeis of exemination end/or investigation, in my opinion, death occurred et the time, dete end piece, end due to the ceuse(s) end menner steted.

29b. Signature and title of certifier: ▶ T. Rodd MD

29c. License number: D42800

29d. Date signed *(Month, Day, Year)*: 11/18/98

30. Neme end address of person who completed ceuse of deeth (Item 23e) (Type, Print): T. Rodd MD 319 S. Union Ave, Hdg, Md, 21078

State Registrar

31. Dete filed *(Month, Day, Year)*: NOV 18 1998

32. Registrer's Signeture: ▶ P. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37022

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Kenneth Leroy MYERLY

2. Dete of Deeth — Month: November Day: 24, Year: 1998

3. Time of Deeth: 8 20 pm

4e. Feclity Neme *(If not institution, give street and number)*: Washington County Hospital

4b. City, Town, or Location of Deeth: Hagerstown

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 212-14-6434

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. lest birthday)*: 78 Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 10, 1920

9. Birthpiece *(State or Foreign Country)*: Maryland

Usuel Residence of Decedent

10a. State: Maryland

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 741 Antietam Drive

10f. Zip Code: 21742

10g. Citizen of What Country?: USA

11. Maritel Stetus: 1☐ Never Married 2☒ Merried 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Bleck, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grede completed)*: Elementery/Secondary (0-12): 8 — College (1-4or 5+): 0

16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: mechanic

16b. Kind of Business/Industry: spring works

17. Fether's Neme *(First, Middle, Last)*: Charles Edgar Myerly

18. Mother's Name *(First, Middle, Maiden Surneme)*: Maude Leamore Stultz

19e. Informant's Neme/Relationship *(Type, Print)*: Loretta Myerly - wife

19b. Meiling Address *(Street end Number or Rurel Route Number, City or Town, State, Zip Code)*: 741 Antietam Dr., Hagerstown, Md. 21742

20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donation 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, crematory or other piece)*: Rest Haven Cemetery

Dete: 11-28-98

20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: Scott Minnich

22. Neme end Address of Feclity: MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Heelth and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line.

Approximete Intervel Between Onset end Death

Immediate Ceuse (Final disease or condition resulting in death) e. Metastatic carcinoma of Parotid gland — Due to (or es e consequence of): — WEEKS

Sequentielly list conditions, if eny, leading to immediete ceuse. Enter Underlying Cause (Disease or injury thet initieted events resulting in deeth) Lest

b. — Due to (or es e consequence of):

c. — Due to (or es e consequence of):

d.

Part ii. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Pert I.: Congestive Heart failure

23b. Did tobecco uee contribute to the cauee of deeth? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☑ No

24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Piece of Death *(Check only one)*: Hospital: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☑ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Dete of Injury *(Month, Dey Yeer)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end piece, end due to the cause(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) end manner stated.

29b. Signature end title of certifier:

29c. License number: D21457

29d. Date signed *(Month, Dey, Yeer)*: 11/25/98

30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print): ABDUL WAHEED MD-12821 - OAK HILL AVE. HAGERSTOWN, MD 21742

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours efter death.
To the Funeral Director: After this certificate hes been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Dete filed *(Month, Day, Year)*: NOV 3 0 1998

32. Registrer's Signeture: Teresa G. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37023

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CARROLL STEVENSON MARSHALL SR.

2. Date of Death (Month, Day, Year): NOV. 24, 1998

3. Time of Death: 0138

4a. Facility Name (If not institution, give street and number): Washington County Hospital

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 214-09-5141

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 86 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): December 25, 1911

9. Birthplace (State or Foreign Country): West Virginia

Usual Residance of Decedant

10a. State: Maryland

10b. County: Washington

10c. City, Town or Location: Funkstown

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: P.O. Box 373 West Poplar Street

10f. Zip Coda: 21734

10g. Citizen of What Country?: U.S.A.

To Be Completed by Funeral Director

11. Marital Status: 1 [ ] Naver Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Giva Yaar or Datas: WW II

13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 1 [ ] Yas 2 [X] No Specify:

14. Race - Amaricen Indien, Bleck, Whita, atc. Specify: White

15. Dacedent's Educetion (Specify onfy highast grada complatad): Elementary/Secondary (0-12): 5 College (1-4or 5+):

16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired): Maintenance Worker

16b. Kind of Business/Industry: Cheese Manufacturer

17. Fathar's Name (First, Middla, Last): Harry Marshall

18. Mothar's Name (First, Middle, Maiden Sumama): Mary Mag Wilson

19a. Informant's Name/Ralationship (Type, Print): Joseph D. Marshall

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda): 37 Madison Avenue, Hagerstown, Maryland 21740

20a. Mathod of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Ramoval from Stata 4 [ ] Donation 5 [ ] Othar (Specify)

20b. Place of Disposition (Name of cematary, cramatory or other place): Rose Hill Cemetery

Data: 11-27-98

20c. Location - City or Town, Stata: Hagerstown, Maryland

21. Signature of Funaral Sarvice Licensee: ▶ R. Noel Brady

22. Nama and Address of Facility: Andrew K. Coffman Funeral Home, Inc. 40 East Antietam Street, Hagerstown, Md. 21740

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Entar tha disaasa, or complications that causad tha daath. Do not antar tha moda of dying, such as cardiac or respiratory errast, shock, or haart failura. List only ona causa on aach line.

Approximeta Interval Between Onset and Daath

Immediata Causa (Final disaasa or condition resulting in daath)

a. Septicemia — Approximeta Interval: 1 day

Due to (or as a consaquanca of):

Sequentially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Disease or Injury that initiated avants rasulting in death) Last

b. Cellulitis right upper Extremites

Due to (or es e consaquance of):

c.

Dua to (or as a consequance of):

d.

Part II. **Other eignificent conditions** contributing to death but not rasulting in the underlying cause givan in Part I.

Chronic obstructive Pulmonary disease

Arteriosclerotic heart disease

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performad? 1 [ ] Yas 2 [X] No

24b. Ware autopsy findings availabla prior to complation of ceusa of daath? 1 [ ] Yas 2 [ ] No

25. Was cesa rafarrad to medical axaminer? 1 [ ] Yas 2 [X] No

26. Place of Daath (Chack only ona): Hospital: 1 [X] Inpatiant 2 [ ] ER/Outpatiant 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Rasidance 6 [ ] Othar (Specify)

27. Manner of Deeth: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicida 5 [ ] Panding invastigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yas 2 [ ] No

28d. Describe how injury occurred

28e. Piece of Injury - At homa, tarm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29a. Cartifiar (Check only one): 1 [X] **Certifying Physician:** To tha bast of my knowladga, daath occurrad at the time, date end place, and dua to tha causa(s) and manner as steted. 2 [ ] **Medical Examinar:** On tha basis of examinetion and/or invastigetion, in my opinion, death occurred at tha tima, data and place, and due to the cause(s) and manner stated.

29b. Signetura end titla of certifiar: ▶ [signature], MD

29c. Licansa number: D01040

29d. Dete signed (Month, Day, Year): 11-25-98

30. Nama and addrass of person who complatad ceuse of death (Item 23a) (Typa, Print): Dr. Barry Cohen 18706 Crestwood Dr. Hag. Md.

State Registrar

31. Data filed (Month, Day, Yaar): NOV 30 1998

32. Registrar's Signatura: ▶ [signature] G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Carroll Stevenson Marshall, Sr.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37024

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Frederick Elbert Miles, Jr.

2. Date of Death: Month NOV Day 20 Year 1998

3. Time of Death: 4:34 am.

4a. Facility Name (If not institution, give street and number): Washington County Hospital

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 223-38-4495

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 65 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): December 14, 1932

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 701 Forest Drive

10f. Zip Code: 21740

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementery/Secondary (0-12): 8

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Detail

16b. Kind of Business/Industry: New Car Dealer

17. Father's Name (First, Middle, Last): Frederick Elbert Miles, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Lucille Dade

19a. Informant's Name/Relationship (Type, Print): Helen E. Miles Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 701 Forest Drive Hagerstown, Maryland 21740

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Rose Hill Cemetery

Date: 11/24/98

20c. Location - City or Town, Stete: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: Gerald N. Minnich

22. Name and Address of Facility: Gerald N. Minnich Funeral Home, 305 N. Potomac Street, Hagerstown, Maryland 21740

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	ATHEROSCLEROTIC CARDIOVASCULAR DISEASE	1 MONTH
Due to (or as e consequence of): b.	RENAL FAILURE	48 hours
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last — Due to (or es e consequence of): c.	CHOLECYSTITIS.	48 hours.
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: none

23b. Did tobacco uae contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of deeth? 1 [ ] Yes 2 [X] No

25. Was case referred to medical exeminer? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of exemination end/or investigation, In my opinion, death occurred et the time, date and piece, end due to the cause(s) and manner stated.

29b. Signature end title of certifier: Mayan J May

29c. License number: D28365

29d. Date signed (Month, Day, Year): 11.23.98

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): MAWZAR J SHAFI 368 MILL STREET HAGERSTOWN MD 21740.

State Registrar

31. Date filed (Month, Day, Year): NOV 23 1998

32. Registrar's Signature: G. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attanding physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37025

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
JOHN	HENRY	MAUK	November 17, 1998	12:40 PM

4e. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
12815 The Terrace	Hagerstown	Washington

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	If Under 1 Year Days	If Under 24 Hrs. Hours	If Under 24 Hrs. Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
210-26-7280	1☐ M 2☐ F	65 Yrs.					June 17, 1933	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Washington	Hagerstown	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
12815 The Terrace	21742	U.S.A.

11. Marital Status	12. Was Decedent Ever In U.S. Armed Forces?	13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.)	14. Rece - American Indien, Bleck, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☒ Yes 2☐ No If Yes, Give Year or Dates: 1952-1956	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grede completed)		16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Vice President	Insurance Agency

17. Father's Neme (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surneme)
Frederick William Mauk	Mary Elizabeth Young

19a. Informent's Name/Reletionship (Type, Print)	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)
Susan V. Mauk	12815 The Terrace, Hagerstown, Maryland 21742

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other piece)	Dete	20c. Location - City or Town, Stete
☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)	Manor Church Cemetery	11-20-98	Tilghmanton, Maryland

21. Signeture of Funeral Service Licensee	22. Name end Address of Facility
R. Neil Brady	Andrew K. Coffman Funeral Home, Inc. 40 East Antietam Street, Hagerstown, Md. 21740

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Death

Immediate Ceuse (Finel disease or condition resulting in death)

a. LUNG CANCER — 6 months

Due to (or as e consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest

b.

Due to (or es e consequence of):

c.

Due to (or as e consequence of):

d.

Part II. **Other eignificant conditions** contributing to deeth but not resulting in the underlying cause given in Part I.

BRAIN METASTASIS

23b. **Did tobacco use contribute to the cause of death?** 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed?	24b. Were autopsy findings eveileble prior to completion of cause of deeth?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Deeth	28a. Dete of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how Injury occurred
1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify)	28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)

1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, date and piece, end due to the cause(s) end manner es steted.

2☐ **Medical Examiner**: On the basis of examination end/or Investigetion, in my opinion, death occurred et the time, date and place, end due to the ceuse(s) end menner stated.

29b. Signeture end title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)
Hind Hamdan MD	D-46473	11/17/98

30. Neme end address of person who completed cause of death (Item 23e) (Type, Print)

Hind Hamdan, M.D. 363 South Cleveland Ave.,Hagerstown, Md. 21740

State Registrar

31. Dete filed (Month, Day, Year)	32. Registrer's Signature
NOV 19 1998	Donna G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37026

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Melvin Eugene Miller

2. Date of Death: Month NOV. Day 14 Year 98

3. Time of Death: 7:10 A

4e. Facility Name (If not institution, give street and number): Washington County Hospital

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 217-18-7366

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 74 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb. 23, 1924

9. Birthplece (State or Foreign Country): Virginia

Usuel Residence of Decedent

10a. State: Maryland

10b. County: Washington

10c. City, Town or Location: Maugansville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 13920 Green Mt. Drive

10f. Zip Code: 21767

10g. Citizen of Whet Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Yeer or Dates: 1941-61

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 10; College (1-4or 5+): 0

16a. Decedent's Usuel Occupation (Give kind of work done duning most of working life. DO NOT use retired): service supervisor

16b. Kind of Business/Industry: retail store

17. Fether's Name (First, Middle, Last): John Edgar Miller

18. Mother's Name (First, Middle, Maiden Sumame): Olive B. Good

19e. Informant's Name/Reletionship (Type, Print): Clara E. Barnes - daughter

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 1236 Magnolia Court, Hagerstown, Md. 21742

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)

20b. Pleca of Disposition (Name of cemetery, crematory or other place): Cedar Lawn Memorial Park

Date: 11-18-98

20c. Location - City or Town, Stete: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: Scott M Mannich

22. Name end Address of Facility: MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Peges 1 end 2 should be filed within 72 hours efter death with the Marylend Department of Health end Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximete Intervel Between Onset end Death

Immediate Ceuse (Final diseese or condition resulting in deeth)
e. Cardiac arrest — Instant

Due to (or es e consequence of):
b. Coronary artery disease — years

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting in death) Lest
Due to (or es e consequence of):
c.

Due to (or es e consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
chronic obstructive pulmonary disease
Renal Failure
Abdmnal aortic aneurysm

23b. **Did tobacco use contribute to the cause of death?** 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☑ No

24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☑ No

26. Plece of Deeth (Check only one)
Hospitel: 1☑ Inpatient 2☐ ER/Outpetient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☑ Other (Specify) Extended Care Facility

27. Manner of Deeth: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☑ No

28d. Describe how Injury occurred

28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours efter deeth.
To the Funeral Director: After this certificate hes been signed by the ettending physician end completely filled in by the funeral director, pege 2 should be detached for use es the burial-transit

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end place, end due to the cause(s) end manner as steted. 2☐ **Medical Examiner:** On the besis of examination end/or investigation, in my opinion, death occurred et the time, date end placa, end due to the cause(s) and menner stated.

29b. Signature end title of certifier

29c. License number: D 50882

29d. Date signed (Month, Day, Year): 11/14/98

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)
NEAL PATACHIONE, M.D. 11110 Medical Campus Road Suite 107, Hagerstown MD 21740

State Registrar

31. Date filed (Month, Day, Year): NOV 17 1998

32. Registrar's Signature: Geneva D. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 37027

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ROBERT J MONGAN
2. Date of Death: Month 11 Day 13 Year 1998
3. Time of Death: 5:30AM
4e. Facility Name (If not institution, give street and number): WESTERN MARYLAND CENTER
4b. City, Town, or Location of Death: HAGERSTOWN
4c. County of Death: WASHINGTON

Funeral Director

5. Social Security Number: 217-10-3291A
6. Sex: 1 X M 2 ☐ F
7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 6/03/15
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: WASHINGTON
10c. City, Town or Location: HAGERSTOWN - BOONSBORO
10d. Inside City Limits: 1 ☐ Yes 2 X No
10e. Street and Number: 21536 RIDENOUR RD
10f. Zip Code: MD 21713
10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 8 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Self Employed
16b. Kind of Business/Industry: Farmer

17. Father's Name (First, Middle, Last): John Calvin Mongan
18. Mother's Name (First, Middle, Maiden Surname): Rose Smith

19a. Informant's Name/Relationship (Type, Print): Maxine E. Mongan Wife
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 21536 Ridenour Road Hagerstown, Maryland 21740

20e. Method of Disposition: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Beaver Creek Cemetery
Date: 11/18/98
20c. Location - City or Town, State: Beaver Creek, Maryland

21. Signature of Funeral Service Licensee: Gerald N. Minnich
22. Name and Address of Facility: Gerald N. Minnich Funeral Home 305 N. Potomac Street Hagerstown, Maryland 21740

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death)
a. HEART FAILURE
Due to (or as a consequence of):

Sequentlelly list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last
b. ISCHEMIC HEART DISEASE
Due to (or es e consequence of):
c.
Due to (or as a consequence of):
d. LEFT HEMISPHERE STROKE

Part II. **Other elgnificent conditions** contributing to deeth but not resulting in the underlying cause given in Part I.
PULMONARY EDEMA
STROKE WITH COMPLETE (R) HEMIPARESIS

23b. Did tobacco uae contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 X No
24b. Were autopsy findings eveilable prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was cese referred to medical examiner? 1 ☐ Yes 2 X No
26. Plece of Deeth (Check only one): Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X **Certifying Phyalcian:** To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and menner as stated. 2 ☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) and manner stated.
29b. Signature and title of certifier: MD
29c. License number: D41112
29d. Date signed (Month, Dey, Yeer): 11.13.98 5:30am
30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): DR. H. NEWBOLD 1500 PENNSYLVANIA AVE HAGERSTOWN

State Registrar

31. Date filed (Month, Day, Year): NOV 16 1998
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37028

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: HELEN LOUISE MOWEN

2. Date of Death Month / Day / Year: November 12 1998

3. Time of Death: 0206

4e. Facility Name *(If not institution, give street and number)*: Washington County Hospital

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 219-20-1954

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 73 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: November 30, 1924

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 16237 Broadfording Road

10f. Zip Code: 21740

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 9 / College (1-4or 5+):

16e. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Lawrence Martin Angle

18. Mother's Name *(First, Middle, Maiden Surname)*: Ida Elizabeth Bowers

19a. Informant's Name/Relationship *(Type, Print)*: Larry A. Longerbeam

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 16237 Broadfording Road, Hagerstown, Md. 21740

20e. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Broadfording Cemetery

Date: 11-16-98

20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: R. Neal Brady

22. Name and Address of Facility: Andrew K. Coffman Funeral Home, Inc. 40 East Antietam Street, Hagerstown, Md. 21740

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Ventricular Fibrillation due to

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Acute Myocardial Infarction

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ **Yes** 2☒ **No** 3☐ **Probably** 4☐ **Unknown**

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier: [illegible] MD

29c. License number: MD 6641

29d. Date signed *(Month, Day, Year)*: 11-12-98

30. Name and address of person who completed cause of death (Item 29a) *(Type, Print)*: ER Physician 389 Pub [illegible] Hagerstown MD 21740

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 13 1998

32. Registrar's Signature: Denise G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Helen Mowen

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 37029

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Lloyd H. Martin
2. Date of Death Month Day Yeer: November 10 1998
3. Time of Death: 22:53
4a. Facility Neme *(If not institution, give street end number)*: Washington County Hospital
4b. City, Town, or Location of Death: Hagerstown
4c. County of Deeth: Washington

Funeral Director

5. Socisl Security Number: 220-18-1401
6. Sex: 1☒M 2☐F
7. Age *(In yrs. last birthdey)*: 74 Yrs. — If Under 1 Year: Months / Deys; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Dey, Year)*: April 26, 1924
9. Birthplace *(Stete or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: PA
10b. County: Franklin
10c. City, Town or Location: Chambersburg
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street end Number: 238 Cornertown Road
10f. Zip Code: 17201
10g. Citizen of Whet Country?: U.S.

11. Marital Status: 1☐Never Merried 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 1☐Yes 2☒No *Specify:*
14. Rece - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Eduestion *(Specify only highest grede completed)*: Elementary/Secondary (0-12): 8; College (1-4or 5+):
16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: President
16b. Kind of Business/Industry: Food Processing/Bakery

17. Fether's Neme *(First, Middle, Last)*: Abram Martin
18. Mother's Name *(First, Middle, Maiden Surneme)*: Susie Horst

19a. Informent's Name/Relationship *(Type, Print)*: Mrs. Lois Wenger Martin
19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 238 Cornertown Road Chambersburg, PA 17201

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donetion 5☐Other *(Specify)*
20b. Place of Disposition *(Neme of cemetery, cremetory or other place)*: Air Hill Cemetery
Date: 11/14/98
20c. Location - City or Town, State: Chambersburg, PA 17201

21. Signature of Funeral Service Licensee: Thomas L. Geisel
22. Neme end Address of Facility: Thomas L. Geisel Funeral Home, Inc. 333 Falling Spring Road Chambersburg, PA 17201

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on eech line.

Approximete Intervel Between Onset end Deeth

Immediate Ceuse (Final diseese or condition resulting in death)
e. Coronary Artery Disease — yrs
Due to (or es e consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Lest
b. Sick Sinus syndrome — yrs
Due to (or es e consequence of):
c. Carotid Stenosis — yrs
Due to (or es e consequence of):
d.

Part II. **Other significant conditione** contributing to death but not resulting in the underlying ceuse given in Part I.
hyperlipidemia
hypertension

23b. Did tobacco use contribute to the cauea of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Wes en eutopsy performed? 1☐Yes 2☒No
24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? 1☐Yes 2☒No

25. Wes case referred to medical examiner? 1☐Yes 2☒No

26. Place of Deeth *(Check only one)*: Hospital: 1☒Inpatient 2☐ER/Outpetient 3☐DOA; Other: 4☐Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Menner of Deeth: 1☒Neturel 2☐Accident 3☐Sulcide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury et Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Phyeicien**: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the ceuse(s) end menner es steted. 2☐**Medical Examiner**: On the besis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end piece, end due to the ceuse(s) and menner stated.

29b. Signature end title of certifier: M.P. Clark
29c. License number: D50813
29d. Date signed *(Month, Dey, Year)*: 11/10/98

30. Neme end eddress of person who completed ceuse of deeth (Item 23a) (Type, Print): Dr. Neil O'malley 11110 Medical Campus Rd. Hag. Md

State Registrar

31. Date filed *(Month, Dey, Year)*: NOV 13 1998
32. Registrar's Signature: [illegible] B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Lloyd Horst Martin

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37030

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Leona Mary Mills
2. Date of Deeth — Month: November Dey: 5 Year: 1998
3. Time of Death: 11:00A.
4a. Facility Neme *(If not institution, give street end number)*: Washington County Hospital
4b. City, Town, or Location of Deeth: Hagerstown,
4c. County of Deeth: Washington

Funeral Director

5. Social Security Number: 217-30-5585
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 73 Yrs. — If Under 1 Yeer: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Day, Yeer)*: April 5,1925
9. Birthplace *(Stete or Foreign Country)*: MD

Usuel Residence of Decedent

10a. Stete: MD
10b. County: Washington
10c. City, Town or Location: Big Pool
10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 12720 Pecktonville Road
10f. Zip Code: 21711
10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Merried 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Yeer or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Bleck, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grede completed)*: Elementary/Secondary (0-12): 12 years — College (1-4or 5+): 0
16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Sales Clerk
16b. Kind of Business/Industry: Department Store

17. Fether's Neme *(First, Middle, Last)*: Bruce Elwood Shives
18. Mother's Name *(First, Middle, Maiden Surneme)*: Edna Louise Miller

19a. Informent's Neme/Relationship *(Type, Print)*: Joi Mills
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 12720 Pecktonville Rd. Big Pool, MD 21711

20e. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Place of Disposition *(Neme of cemetery, crematory or other place)*: Parkhead Cem. Nov.9,1998
20c. Location - City or Town, Stete: Big Pool,MD

21. Signeture of Funerel Service Licensee: Dennis A Zinn
22. Name and Address of Feciility: Thompson Funeral Home,Inc. P.O.Box 310 Clear Spring,MD 21722

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset end Death

Immediate Ceuse (Finel diseese or condition resulting in death): a. (PRESUMED) MYOCARDIAL INFARCTION — HOURS
Due to (or es a consequence of):
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest:
b. HYPERTENSION — YEARS
Due to (or as a consequence of):
c. HYPERLIPIDEMIA — YEARS
Due to (or as e consequence of):
d.

Part II. **Other significant conditione** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Deeth *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☑ DOA — Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*
27. Manner of Deeth: 1☐ Nelurel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Dete of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how Injury occurred
28e. Plece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner**: On the basis of examination end/or investigetion, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) and menner stated.

29b. Signeture end title of certifier: DWooster MD
29c. License number: D22043
29d. Dete signed *(Month, Day, Yeer)*: 11/6/98.

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): Dr Wooster 11110 Medical Campus Rd Hagerstown Maryland

State Registrar

31. Dete filed *(Month, Day, Yeer)*: NOV 0 9 1998
32. Registrar's Signeture: Linda G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Leona Mary Mills

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37031

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ALFRED D. NOYES, SR.

2. Date of Death: Month Nov Day 4 Year 1998

3. Time of Death: 3:20 am

4a. Facility Name (If not Institution, give street and number): 22010 Beallsville Road

4b. City, Town, or Location of Death: Barnesville

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 213-40-7987

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 91 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug 27 1907

9. Birthplace (State or Foreign Country): Wash. DC

Usual Residence of Decedent

10a. State: MD

10b. County: Montgomery

10c. City, Town or Location: Barnesville

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 22010 Beallsville Road

10f. Zip Code: 20838

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 6

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Juvenile Court Judge

16b. Kind of Business/Industry: Law

17. Father's Name (First, Middle, Last): Edmund S. Noyes

18. Mother's Name (First, Middle, Maiden Surname): Jeanette Dunkin

19a. Informant's Name/Reletionship (Type, Print): Nancy Moringstar-daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 22520 Peach Tree Rd., Boyds, MD 20841

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other piece): Monocacy

Date: 11/7

20c. Location - City or Town, State: Beallsville, MD

21. Signature of Funeral Service Licensee: Will C Hilton

22. Name and Address of Facility: Hilton Funeral Home, Barnesville, MD 20838

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset end Death

Immediete Cause (Finel disease or condition resulting in death) e. Prostate Cancer — One Year

Due to (or es e consequence of):

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury thet initiated events resulting in death) Last

b.

Due to (or es e consequence of):

c.

Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobecco use contribute to the cause of deeth? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Deeth (Check only one): Hospitel: 1 [ ] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Deeth: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted. 2 [ ] **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred et the time, dete end place, end due to the ceuse(s) end manner stated.

29b. Signature and title of certifier: Robert Mell MD

29c. License number: D33680

29d. Date signed (Month, Dey, Year): November 4, 1998

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print): Kenneth Miller, MD 18111 Prince Philip Dr. Olney, MD 20852

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Dete filed (Month, Day, Year): NOV 10 1998

32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98-37032

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last)	2. Dete of Deeth (Month, Day, Yeer)	3. Time of Deeth
NINA EVELYN NEADY	NOVEMBER 21 1998	08:34AM

4e Facility Neme (If not institution, give street end number)	4b. City, Town, or Location of Death	4c. County of Deeth
THE JOHNS HOPKINS HOSPTIAL	BALTIMORE CITY	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. lest birthday)	If Under 1 Year: Months / Deys	If Under 24 Hrs.: Hours / Min.	8. Dete of Birth (Month, Dey, Yeer)	9. Birthplace (Stete or Foreign Country)
577465013	1☐ M 2☒ F	65 Yrs.			Jul 20, 1933	Parsonburg, Md

Usuel Residence of Decedent

10e. Stete	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Prince George's	Hyattsville	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of Whet Country?
3902 74th Ave	20784	USA

11. Maritel Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.)	14. Race - American Indien, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grede completed)		18e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Nursing Assistant	Private

17. Fether's Neme (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surneme)
John W. Yerkie	Margaret Humphries

19e. Informent's Neme/Reletionship (Type, Print)	19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)
Michael K. Neady/ Husband	3902 74th Ave Hyattsville MD 20784

20a. Method of Disposition	20b. Place of Disposition (Neme of cemetery, cremetory or other piece)	Date	20c. Location - City or Town, Stete
1☒ Burial 2☐ Cremation 3☒ Removel from Stete 4☐ Donetion 5☐ Other (Specify)	Green Hill Cemetery	11/27	Waynesboro PA

21. Signeture of Funeral Service Licensee	22. Neme end Address of Facility
James A. Bowersox	Grove Funeral Home, Inc. 50 S Broad ST Waynesboro PA 17268

Physician /Medical Examiner

23a. Pert I. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on eech line.

		Approximete Intervel Between Onset end Death
Immediete Ceuse (Final disease or condition resulting in deeth)	e. FULMINANT HEPATIC FAILURE	2 DAYS
Due to (or es e consequence of):	OVERWHELMING SEPSIS	3 DAYS
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest	b. SMALL BOWEL ISCHEMIA	4 DAYS
Due to (or es e consequence of):	c.	
Due to (or es e consequence of):	d.	

Pert II. **Other significent conditione** contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. Did tobacco use contribute to tha cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Was en eutopsy performed?	24b. Were eutopsy findings aveilable prior to completion of cause of death?
1☒ Yes 2☐ No	1☐ Yes 2☒ No

25. Was case referred to medical exeminer?	26. Piece of Deeth (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpetient 2☐ ER/Outpetient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Deeth	28e. Dete of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Piece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify)			28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end manner es steted.
2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end placa, end due to the cause(s) end menner stated.

29b. Signeture end title of certifier	29c. License number	29d. Date signed (Month, Dey, Yeer)
MD	RES-000	NOVEMBER 21, 1998

30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print)
Julie Ann Socia MD 600 NORTH WOLFE ST BALTIMORE, MD 21287-910

State Registrar

31. Date filed (Month, Day, Yeer)	32. Registrar's Signature
NOV 25 1998	G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37033

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Gladys Romaine Nalley

2. Date of Death: Month November Day 12 Year 1998

3. Time of Death: 3:57AM

4a. Facility Name *(If not institution, give street and number)*: Washington County Hospital

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 220-09-9075

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 87 Yrs.

If Under 1 Year: Months ___ Days ___

If Under 24 Hrs.: Hours ___ Min. ___

8. Date of Birth *(Month, Day, Year)*: Feb. 1, 1911

9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Washington

10c. City, Town or Location: Maugansville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 13915 Weaver Avenue

10f. Zip Code: 21767

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8; College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Residence

17. Father's Name *(First, Middle, Last)*: Harry Risher

18. Mother's Name *(First, Middle, Maiden Surname)*: Helen McCain

19a. Interment's Name/Relationship *(Type, Print)*: Bill D. Nalley/Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: P.O. Box 630, Maugansville, Maryland 21767

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Rest Haven Cemetery-Nov. 14, 1998

20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: Douglas A Fiery

22. Name and Address of Facility: Douglas A. Fiery Funeral Home, 1331 Eastern Blvd., N., Hagerstown, Maryland 21742

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	Adult Respiratory Distress Syndrome	6 Days
Due to (or as a consequence of):		
b.	Pneumonia Edema	6 Days
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		
c.	Perforated Stomach	5 Days
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart failure
Dementia with Confusion
Chronic atrial fibrillation

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Samuel Chan

29c. License number: D36655

29d. Date signed *(Month, Day, Year)*: Nov. 12 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 1185 MT. AETNA RD Hagerstown, MD 21740

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 13 1998

32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

Nalley, Gladys

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37034

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Gladys I. Owens

2. Dete of Deeth — Month: Nov. Dey: 20 Yeer: 1998

3. Time of Deeth: 8:25AM

4e. Facility Neme (If not institution, give street end number): Atlantic General Hospital

4b. City, Town, or Location of Deeth: Berlin

4c. County of Deeth: Worcester

Funeral Director

5. Social Security Number: 221-22-7498

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 91 Yrs.

If Under 1 Yeer: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Yeer): Feb.4,1907

9. Birthplace (State or Foreign Country): Dover, DE

Usual Residence of Decedent

10e. State: Maryland

10b. County: Worcester

10c. City, Town or Location: Ocean City

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 423 Bayshore Drive

10f. Zip Code: 21842

10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grede completed): Elementary/Secondary (0-12): 8 College (1-4or 5+):

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Salesperson

16b. Kind of Business/Industry: Dept. Store Strawbridges

17. Father's Name (First, Middle, Last): John Hilyard

18. Mother's Name (First, Middle, Maiden Surname): Gertrude Hudson

19a. Informant's Name/Relationship (Type, Print): Rev. Richard E. Owens

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 423 Bayshore Dr. Unit 6 Ocean City, MD 21842

20e. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Silverbrook Crematory

Date: 11/25/98

20c. Location - City or Town, State: Wilm., DE

21. Signature of Funeral Service Licensee: Richard O. Riddle Mcrrr

22. Name and Address of Feclility: McCrery Funeral Homes, Inc. 3924 Concord Pike Wilm., DE 19803

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

11/20/98. 0826

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23e. Pert1. Enter the disease, conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line.

Approximete Intervel Between Onset end Deeth

Immediate Ceuse (Final disease or condition resulting in death)

e. ACUTE GASTROINTESTINAL BLEED — 3 HRS.

Due to (or es e consequenca of):

b. (R) LUNG MASS

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in deeth) Last

Due to (or es e consequenca of):

c.

Due to (or es a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. Did tobecco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings aveilable prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one) — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Dete of Injury (Month, Day Yeer)

28b. Time of Injury

28c. Injury et Work? 1☐ Yes 2☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Phyeicien:** To the best of my knowledge, death occurred et the time, date end place, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier

29c. License number: D46257

29d. Dete signed (Month, Day, Yeer): 11/20/98

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print): Dr. Edwin Castaneda 9714 Healthway Drive . Berlin, MD 21811

To the Hospital or Attanding Physician: The law requires thet the death certificate be executed within 24 hours after daath.

To the Funeral Director: Aftar this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

GLADYS Owens 221-22-7498 LT

12

State Registrar

31. Date filed (Month, Day, Yeer): NOV 24 1998

32. Registrar's Signeture: Jenna G. Sparks

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37035

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Frances Mary PAOLILLO
2. Dete of Deeth: Month November Day 22 Year 1998
3. Time of Deeth: 10:15 PM
4a. Facility Name (If not institution, give street end number): 6603 Babak Drive
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 058-03-6571
6. Sax: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 83 Yrs.
If Under 1 Yaar: Months / Deys
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Yeer): May 24, 1915
9. Birthpleca (State or Foreign Country): New York

Usuel Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 6603 Babak Drive
10f. Zip Code: 21702
10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yas 2☒ No If Yes, Give Yaar or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 1☐ Yes 2☒ No Specify:
14. Race - Amarican Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 2
16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Accountant
16b. Kind of Business/Industry: Public School System

17. Fether's Name (First, Middle, Last): Andrew Nigro
18. Mother's Name (First, Middle, Maiden Surneme): Lucy DeRogo

19e. Informent's Name/Relationship (Type, Print): Adrienne P. Murphy/Daughter
19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 6603 Babak Drive, Frederick, MD 21702

20e. Mathod of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, crematory or other place): Calvary Cemetery
Date: Nov. 28, 1998
20c. Location - City or Town, Stata: Woodside, New York

21. Signature of Funeral Service Licensee: Richard C. C. Basford MD0021
22. Name and Address of Fecility: Keeney and Basford P.A. Funeral Home 106 East Church St., Frederick, MD 21701

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not entar the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on eech line.

Approximate Intervel Between Onsat and Daath

Immediate Causa (Final diseese or condition resulting in death)
e. Lung Cancer — 6 months
Due to (or es e consequence of):

Sequentially list conditions, if eny, leeding to immadiate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Lest
b.
Due to (or es a consequence of):
c.
Dua to (or as a consaquance of):
d.

Pert II. **Other signifiсent conditions** contributing to death but not resulting in the underlying cause given in Part I.
alzheimer's
aortic stenosis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Piece of Deeth (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28e. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the besis of exeminetion end/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) end menner steted.
29b. Signature and title of certifier: Lloyd H. Alverson MD
29c. License number: D22101
29d. Date signad (Month, Dey, Year): November 23, 1998
30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print): Lloyd H Alverson MD 1475 Taney Ave Frederick Md 21701

State Registrar

31. Date filed (Month, Day, Year): NOV 25 1998
32. Registrar's Signature: Penina G. Spade

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEM #23a PER MD G774 8/26/99 AH

Certificate of Death

Reg. No. 98 37036

Physician /Medical Examiner

1. Decedant's Name *(First, Middle, Last)*: Herman Abram Poole

2. Date of Death Month Day Year: November 12,1998

3. Time of Death: 11:00 PM

4a. Facility Name *(If not institution, give street and number)*: Northampton Manor Nursing Home

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 213-16-2231

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: February 18,1912

9. Birthplace *(State or Foreign Country)*: Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Gaithersburg

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 431 Gaither Street

10f. Zip Code: 20877

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowad 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American indian, Black, Whita, atc. *Specify:* White

15. Decedent's Education *(Spacify only highest grade completed)*: Elementary/Secondary (0-12): 11 | College (1-4or 5+):

16a. Decedent's Usual Occupetion *(Give kind of work done during most of working life. DO NOT use ratired)*: Carpenter

16b. Kind of Business/Industry: Naval Hospital

17. Father's Name *(First, Middle, Last)*: Abram G. Poole

18. Mother's Name *(First, Middle, Maiden Surneme)*: Annie R. Main

19a. Informant's Name/Relationship *(Type, Print)*: Preston C. Poole - Brother

19b. Malling Address *(Street and Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 4074 Boetler Road, Mount Airy, Maryland 21771

20a. Method of Disposition: 1☒ Burial 2☐ Crametion 3☐ Removal from Stata 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Neme of cemetery, cremetory or other place)*: Pleasant Hill Cemetery

Date: 11/16/98

20c. Location - City or Town, State: Monrovia, Maryland

21. Signature of Funeral Service Licensee: Olin L. Molesworth

22. Name and Address of Facility: Olin L. Molesworth P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872-0117

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onsat and Death

Immediate Cause (Final disease or condition resulting in daath)

a. ~~Acute Pump Failure~~ MYOCARDIAL INFARCTION — ~~11~~ 11 days

Due to (or as a consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated events resulting in daath) Last

b. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE — YEARS

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.

SEVERE AORTIC STENOSIS

DEMENTIA

~~PROLONGED DEFIBRILLATION~~

~~Dementia~~

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of causa of death? 1☐ Yes 2☐ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accidant 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be detarmined

28a. Date of Injury *(Month, Dey Yeer)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Cartifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurrad at tha tima, date and place, and due to tha causa(s) and manner as stated. 2☐ **Medical Examiner:** On tha basis of examination and/or Investigation, in my opinion, daath occurred at the tima, data and place, and dua to the cause(s) end mainer stated.

29b. Signatura and title of certifier:

29c. Licanse number: D32071

29d. Date signed *(Month, Day, Year)*: November 13, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Richard L. Gough, M.D., 19 Frederick St., Walkersville, Md. 21793

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 16 1998

32. Registrar's Signature: Geneva B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Haalth and Mental Hygiana. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requiras that tha death certificate be executed within 24 hours after daath.
To the Funeral Director: After this certificata has been signed by the attanding physician and completaly filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37037

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Walter George PAGE

2. Data of Death (Month, Day, Year): November 10, 1998

3. Time of Death: 11:18 A.M.

4a. Facility Name (If not institution, give street and number): Suburban Hospital

4b. City, Town, or Location of Death: Bethesda

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 219-12-4472

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 91 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 17, 1907

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Adamstown

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 2775 Washington Street

10f. Zip Code: 21710

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Naver Marriad 2 [ ] Married 3 [XX] Widowed 4 [ ] Divorced

12. Was Decedant Evar in U.S. Armed Forces? 1 [ ] Yes 2 [XX] No If Yes, Give Year or Dates:

13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 5; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Farmer

16b. Kind of Business/Industry: Farming

17. Fathar's Name (First, Middle, Last): George Edward Page

18. Mother's Name (First, Middle, Maiden Surname): Virginia Remick

19a. Informant's Name/Relationship (Type, Print): Robert L. Page, Sr./Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5618 Honeysuckle Court, Frederick, Md. 21703

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mount Olivet Cemetery

Date: Nov. 13, 1998

20c. Location - City or Town, State: Frederick, MD

21. Signature of Funeral Service Licensee: Richard C. C. Basford MO0021

22. Name and Address of Facility: Keeney and Basford Funeral Home 106 East Church Street, Frederick, MD 21701

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the daath. Do not anter tha mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Intervel Between Onset end Death

Immediate Cause (Final disease or condition resulting in death)

a. Closed head injury — days

Due to (or as a consequenca of):

b. Multiple fractures — days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consaquance of):

c. Fall from ladder

Due to (or as a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uaa contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of causa of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Homa 5 [ ] Residenca 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Neturel 2 [X] Accident 3 [ ] Suicida 4 [ ] Homicide 5 [ ] Panding investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year): November 2, 1998

28b. Time of Injury: unknown

28c. Injury at Work? 1 [ ] Yes 2 [X] No

28d. Describe how injury occurred: Fall from ladder

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Home

28f. Location (Streat and Number or Rural Route Number, City or Town, State): 2775 Washington St. Adamstown Maryland

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [ ] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date end piece, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner**: On the basis of examination and/or investigation, In my opinion, death occurred et the time, date and pleca, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: Patricia L. Tomsko, MD

29c. License number: D51916

29d. Date signed (Month, Day, Year): November 10, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Patricia L. Tomsko, MD, 11140 Rockville Pike, #348, Rockville, MD 20852

State Registrar

31. Date filed (Month, Day, Year): NOV 12 1998

32. Registrar's Signature: B. Lomax

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

WALTER GEORGE PAGE 11/10/98 11:18AM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37038

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): NORMA M. PEARCE

2. Date of Death: Month Nov. Day 19 Year 1998

3. Time of Death: 1:35 p.m.

4a. Facility Name (If not institution, give street and number): Egle Nursing Home

4b. City, Town, or Location of Death: Lonaconing

4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 220-10-9305

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 4, 1914

9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: MD

10b. County: Allegany

10c. City, Town or Location: McCoole

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 25310 Parkland Drive

10f. Zip Code: 21562

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) 11 / College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Coning Machine Operator

16b. Kind of Business/Industry: Textile Manufacturing

17. Father's Name (First, Middle, Last): Joseph W. Malcolm

18. Mother's Name (First, Middle, Maiden Surname): Leigh Smith

19a. Informant's Name/Reletionship (Type, Print): John Patrick Pearce/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt. 1, Box 125 Burlington, WV 26710

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Potomac Memorial Gardens

Date: Nov. 22 1998

20c. Location - City or Town, State: Keyser, WV

21. Signature of Funeral Service Licensee: ▶ Brian L. Smith

22. Name and Address of Facility: Rotruck-Smith Funeral Home 85 S. Main Street Keyser, WV 26726

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Myocardial Failure — 72 hrs.

Due to (or as a consequence of):
b. Generalized Arteriosclerosis — 6 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dementia, Alzheimers Type

Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ L.R. Miles JR MD

29c. License number: D07004

29d. Date signed (Month, Day, Year): Nov. 20, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): L.R. MILES, JR., M.D. 57 JACKSON ST. LONACONING MD 21539

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

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State Registrar

31. Date filed (Month, Day, Year): NOV 24 1998

32. Registrar's Signature: ▶ [signature] P. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37039

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Clara Ella Price
2. Date of Death (Month, Day, Year): November 15, 1998
3. Time of Death: 10:12 PM
4a. Facility Name (If not institution, give street and number): Salisbury Center: Genesis ElderCare
4b. City, Town, or Location of Death: Salisbury, MD
4c. County of Death: Wicomico

Funeral Director

5. Social Security Number: 213-18-4316
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 84 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 13 1914
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Wicomico
10c. City, Town or Location: Salisbury
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1108 Sonnye Lane
10f. Zip Code: 21801
10g. Citizen of Whet Country?: U.S.A

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedant Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Domestic
16b. Kind of Business/Industry: None

17. Father's Name (First, Middle, Last): Able Spence
18. Mother's Name (First, Middle, Maiden Surname): Cecie Stevenson

19a. Informent's Neme/Ralationship (Type, Print): Bertha Cahn (Daughter)
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4674 Shumate DR.Stone Mountain GA 30083

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stete 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Springhill Mem.Garden — Data: 11/20/98
20c. Location - City or Town, Stete: Hebron,Md.

21. Signatura of Funarel Service Licensee: ▶ Gladys B. Stewart
22. Nama and Address of Facility: Stewart Funeral Home 821 West Rd.Salisbury,Md.21801

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter tha mode of dying, such es cardiac or respiratory errest, shock, or haert failure. List only one causa on each lina. — Approximata Interval Between Onset and Deeth

Immediate Cause (Final disaese or condition resulting in death): a. Arteriosclerotic Cardiovascular

Due to (or as a consequence of): b. Disease — Years

Sequantially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disease or injury thet initieted avants resulting in death) Last

Due to (or es e consequenca of): c.

Due to (or es e consequence of): d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings eveilable prior to completion of cause of daeth? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☑ Nursing Homa 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. tnjury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Routa Number, City or Town, State)

29a. Certifier (Check only one): 1☑ Certifying Physician: To tha best of my knowledge, death occurred et the tima, data and place, and dua to tha cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at tha time, data and piece, and due to the cause(s) end mannar statad.

29b. Signature and title of certifier: ▶
29c. License number: D39813
29d. Data signed (Month, Day, Year): 11/16/98

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): Mr Kings 1104 Ashbourne Drive Sales MD 21804

State Registrar

31. Date filed (Month, Day, Year): NOV 18 1998
32. Registrer's Signeture: ▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

Item 30 Per PHY Film G768 2-18-99 rja

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37040

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
V. Grace Puschell	November 18, 1998	7:12 P.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Mars Home	North East	Cecil

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
246-28-6808	1☐ M 2☒ F	77 Yrs.			November 25, 1920	North Carolina

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Cecil	North East	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
65 Razor Strap Road	21901	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11		Homemaker	Her own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Joel Osborne	Pearl (Maiden name unknown)

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Charles A. Puschell, Jr./Spouse	65 Razor Strap Road, North East, MD 21901

20a. Method of Disposition	20b. Place of Disposition (Name of cemetary, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	North East Methodist Cem.	Nov. 21 1998	North East, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Robert F. Crouch	Crouch Funeral Home 127 South Main Street, North East, MD 21901

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Subdural Hematoma	Days
Due to (or as a consequence of):	b. Urosepsis	Days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	
Due to (or as a consequence of):	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Alzheimers

Hypertension

Depression

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☑ No	1☐ Yes 2☑ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☑ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ MD	D0047711	November 19, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David Gar El, M.D. 3 Mauldin ave., NOrth East MD 21901 410-287-6616

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 20 1998	▶ Brenda B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37041

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Hyland Hilyard Price
2. Date of Death (Month, Day, Year): November 19, 1998
3. Time of Death: 4:00 AM
4a. Facility Name (If not institution, give street and number): 256 Hollywood Beach Road
4b. City, Town, or Location of Death: Chesapeake City
4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 221-05-9178
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 25, 1916
9. Birthplace (State or Foreign Country): De.

Usual Residence of Decedent

10a. State: Md.
10b. County: Cecil
10c. City, Town or Location: Chesapeake City
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 256 Hollywood Beach Road
10f. Zip Code: 21915
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? [X] Yes 2 [ ] No If Yes, Give Year or Dates: WW 2
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 3
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Standards Engineer
16b. Kind of Business/Industry: DuPont Co.

17. Father's Name (First, Middle, Last): Hyland Leo Price
18. Mother's Name (First, Middle, Maiden Surname): Lauretta Hilyard

19a. Informant's Name/Relationship (Type, Print): Patricia P. Koske, Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 16722 Fort Polaski Ave, Baton Rouge, La. 70817

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): R. A. Ferris & Co., Date: 11/20/98
20c. Location - City or Town, State: West Chester, Pa.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: 259 E. Main St., Gee Funeral Home Elkton, Md. 21921

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Mesothelioma	2 months
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [✓] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [✓] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Monte Makous, MD
29c. License number: D-44783
29d. Date signed (Month, Day, Year): November 20, 1998

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): MONTE MAKOUS, MD 111 WEST High STREET, ELKTON, MD 21921

State Registrar

31. Date filed (Month, Day, Year): NOV 20 1998
32. Registrar's Signature: Geneva G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37042

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Walter Daniel Power

2. Date of Death Month / Dey / Year: NOVEMBER 16, 1998

3. Time of Death: 6:50PM

4a. Facility Neme *(If not institution, give street and number)*: VA MARYLAND HEALTH CARE SYSTEM

4b. City, Town, or Location of Death: PERRY POINT

4c. County of Death: CECIL

Funeral Director

5. Social Security Number: 218-01-5900

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 80 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Dey, Year)*: Feb. 6,1918

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. Stete: Maryland

10b. County: Cecil

10c. City, Town or Location: Perryville

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 828 Aiken Avenue

10f. Zip Code: 21903

10g. Citizen of What Country?: U.S.A.

11. Maritel Stetus: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Yeer or Detes: 1942-45

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12) / College (1-4or 5+): 4 +

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Priest

16b. Kind of Business/Industry: Catholic Diocese of Wilmington, Delaware

17. Fether's Neme *(First, Middle, Last)*: John A. Power

18. Mother's Neme *(First, Middle, Maiden Surname)*: Mary O. Sultzer

19e. Informent's Neme/Reletionship *(Type, Print)*: James Power (nephew)

19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1738 Pleasantville Rd., Forest Hill, Maryland 21050

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*: Most Holy Redeemer Cemetery

Dete: 11/19/98

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Thomas M. Patterson, Sr.

22. Neme end Address of Facility: Lee A. Patterson & Son Funeral Home, Perryville, Maryland 21903-0188

Physician /Medical Examiner

23e. Pert1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert failure. List only one cause on eech line.

Approximete Intervel Between Onset end Death

Immediate Cause (Final disease or condition resulting in deeth) a. ACUTE RENAL FAILURE — 3 MONTH

Due to (or es e consequence of): CONGESTIVE HEART FAILURE — 6 MONTH

Sequentielly list conditions, if any, leading to immediete cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last

b. Due to (or es e consequence of):

c. Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings aveilable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and manner stated.

29b. Signeture and title of certifier: ▶ Fashed Kouli

29c. License number: MD D48271

29d. Date signed *(Month, Day, Year)*: NOVEMBER 16, 1998

30. Neme end address of person who completed cause of death (Item 23a) (Type, Print): FASHED KOULI, M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MD 21902

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: NOV 18 1998

32. Registrar's Signature: ▶ Geneva B. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

POWER, WALTER D.
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37043

Peterson, Kenneth

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Kenneth Rohrer PETERSON

2. Date of Death Month / Day / Year: November 18 1998

3. Time of Death: 8:53PM

4a. Facility Name (If not institution, give street and number): Washington County Hospital

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 213-40-3010

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 55 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 1, 1942

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 720 W. Franklin Street

10f. Zip Code: 21740

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No. If Yes, Give Year or Dates: 1960-63

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): truck driver

16b. Kind of Business/Industry: transportation

17. Father's Name (First, Middle, Last): Axel Michel Petersen

18. Mother's Name (First, Middle, Maiden Surname): Evelyn Elizabeth Talhelm

19a. Informant's Name/Relationship (Type, Print): Sandra J. Petersen-wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 720 W. Franklin Street, Hagerstown, Md. 21740

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Rest Haven Cemetery

Date: 11-23-98

20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: Scott M Minnich

22. Name and Address of Facility: MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Massive Intestine Infarction — Days

Due to (or as a consequence of):

b. Arterio Sclerotic Vascular Disease — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D18127

29d. Date signed (Month, Day, Year): 11/18/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CHIA CHUEN SU MD 370 Mill Street. Hagerstown Md 21740

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): NOV 20 1998

32. Registrar's Signature: Denise G. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37044

Amended Item #11 per fh g774 8/26/99 AH

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ralph Montgomery Ray, Jr.

2. Date of Death Month Day Year: November 17 1998

3. Time of Death: 3:00pm

4a. Facility Name (If not institution, give street and number): 1100 Peach Orchard Lane

4b. City, Town, or Location of Death: Brunswick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 216-22-1079

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 69 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 8 1929

9. Birthplace (State or Foreign Country): Rockville MD

Usual Residence of Decedent

10a. State: MD

10b. County: Frederick

10c. City, Town or Location: Brunswick

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 1100 Peach Orchard Lane

10f. Zip Code: 21716

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: Korean

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Carpenter

16b. Kind of Business/Industry: W.C. Jenkins Co. Gaithersburg, MD

17. Father's Name (First, Middle, Last): Ralph Montgomery Ray, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Mildred C. Howes

19a. Informant's Name/Relationship (Type, Print): Carolyn Green (Sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2526 W. Boss Arnold Rd Knoxville MD 21758

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Hagerstown Crematory

Date: 11/20/99

20c. Location - City or Town, State: Hagerstown, MD

21. Signature of Funeral Service Licensee: Barbara A. Williams

Barbara A. Williams, Owner

22. Name and Address of Facility: John T. Williams Funeral Home 100 Petersville Rd Brunswick MD 21716

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. ASCVD — years

Due to (or as a consequence of):

b. Chronic Alcoholism — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one)

Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Andrew Zarick Jr.

29c. License number: D35164

29d. Date signed (Month, Day, Year): November 20, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Andrew Zarick Jr. MD 1080 W. Patrick St Frederick, MD 21703

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): NOV 20 1998

32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

RKD

98-6717-021

STERLING RICE

ITEMS: #23 PART I, II, 27, 28A-F PER G768 2-9-99 WR

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 37045

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
STERLING RALPH RICE	NOVEMBER 15, 1998	11:25P.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
FREDERICK MEMORIAL HOSPITAL	FREDERICK	FREDERICK

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-18-9163	1[X] M 2[ ] F	78 Yrs.			FEB. 4, 1921	MD.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.	FREDERICK	LIBERTYTOWN	1[X] Yes 2[ ] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
11827 MAIN ST.	21762	U.SA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1[ ] Never Married 2[ ] Married 3[ ] Widowed 4[X] Divorced	1[X] Yes 2[ ] No If Yes, Give Year or Dates:	1[ ] Yes 2[X] No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
6TH		SUPERVISOR	CONSTRUCTION

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
WILLIAM H. RICE JR	HARRISZETTA RYDER

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
JAY G. WHITESIDE	11827 MAIN ST. LIBERTYTOWN MD. 21762

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1[X] Burial 2[ ] Cremation 3[ ] Removal from State 4[ ] Donation 5[ ] Other (Specify)	RESTHAVEN MEM. GAR.	NOV. 23	1998 FRED. MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Gary L. Rollins	GARY L. ROLLINS FUNERAL HOME 110 WEST SOUTH ST. FRED. MD. 21701

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. HEAD AND NECK INJURIES WITH COMPLICATIONS	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSIVE ATHEROSCLEROTIC CARDIOVASCULAR DISEASE, SEIZURE DISORDER AND CIRRHOSIS

23b. Did tobacco use contribute to the cause of death? 1[ ] Yes 2[ ] No 3[ ] Probably 4[X] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1[X] Yes 2[ ] No	1[X] Yes 2[ ] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1[X] Yes 2[ ] No	Hospital: 1[X] Inpatient 2[ ] ER/Outpatient 3[ ] DOA	Other: 4[ ] Nursing Home 5[ ] Residence 6[ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1[ ] Natural 2[ ] Accident 3[ ] Suicide 4[ ] Homicide 5[ ] Pending investigation 6[X] Could not be determined	11-12-98	4:50 P M	1[ ] Yes 2[X] No	SUBJECT FELL DOWN STAIRS

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
RESIDENCE	119276 MAIN STREET, LIBERTYTOWN, MD.

29a. Certifier (Check only one)
1[ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2[X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Stephen S. Radentz MD	O.C.M.E.	NOVEMBER 20.1998

30. Name and address of person who completed cause of death (Item 28a) (Type, Print)
Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 23 1998	▶ Penne B. Spark

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37046

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JAMES EDWARD ROEMBKE

2. Data of Daath — Month: November Day: 11 Year: 1998

3. Tima of Death: 7:30 P.M.

4a. Facility Nama (If not institution, give street and number): Glade Valley Nursing and Rehabilitation

4b. City, Town, or Location of Death: Walkersville

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 311-07-8175

6. Sax: 1 [X] M 2 [ ] F

7. Aga (In yrs. last birthday): 79 Yrs.

If Under 1 Yaar — Months: Deys:

If Under 24 Hrs. — Hours: Min.:

8. Data of Birth (Month, Day, Year): Dec. 20, 1918

9. Birthplaca (State or Foraign Country): Indiana

Usual Rasidance of Decedant

10a. Stata: Maryland

10b. County: Frederick

10c. City, Town or Location: Frederick

10d. Insida City Limits: 1 [X] Yas 2 [ ] No

10e. Street and Number: 1902 Whetstone Court

10f. Zip Coda: 21702

10g. Citizen of Whet Country?: United States

11. Marital Status: 1 [ ] Navar Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1 [X] Yas 2 [ ] No If Yas, Give Year or Datas: 1942-46

13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 1 [ ] Yas 2 [X] No Specify:

14. Race - Amarican Indian, Black, White, etc. Specify: White

15. Decedant's Education (Spacify only highest grada compliatad) — Elementary/Secondary (0-12): College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratirad): Civil Engineering

16b. Kind of Businass/Industry: Government

17. Fether's Name (First, Middle, Last): Edward F. Roembke

18. Mother's Nama (First, Middla, Maidan Surnama): Lizzie C. Williams

19a. Informant's Nama/Relationship (Type, Print): Anita June Bilsland Roembke, wife

19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda): 1902 Whetstone Court Frederick, Maryland 21702

20a. Mathod of Disposition: 1 [ ] Burial 2 [X] Cramation 3 [ ] Ramoval from Stata 4 [ ] Donation 5 [ ] Othar (Specify)

20b. Placa of Disposition (Nama of camatary, cramatory or other placa): Hagerstown Crematory

Data: 11/14/98

20c. Location - City or Town, Stata: Hagerstown, Maryland

21. Signatura of Funaral Sarvica Licansa: Larry R. Savage

22. Nama and Addrass of Facility: Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, Maryland 21702

Physician /Medical Examiner

23a. Part I. Enter the diseasa, or complications that caused the death. Do not enter tha moda of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only ona cause on aach line.

Approximata Interval Between Onsat and Death

Immadiata Causa (Final disaasa or condition resulting in death)

a. Metastatic Carcinoma of Prostate — ~ 5yrs

Dua to (or as a consaquance of):

Sequantially list conditions, if any, leading to immadiata cause. Enter Underlying Causa (Disease or injury that initiated avants resulting in death) Last

b.

Dua to (or as a consaquance of):

c.

Dua to (or es a consaquence of):

d.

Part II. Other signficant conditions contributing to death but not rasulting in tha underlying ceusa givan in Part I.

Adenoid Cystic Carcinoma

Coronary Artery Disease

Parkinsons Disease

23b. Did tobacco use contributa to tha cauaa of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yas 2 [X] No

24b. Wera autopsy findings available prior to compliation of cause of death? 1 [ ] Yes 2 [ ] No

25. Wes casa rafarrad to medical examiner? 1 [ ] Yas 2 [X] No

26. Plece of Death (Chack only one): Hospital: 1 [ ] Inpatiant 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Rasidence 6 [ ] Othar (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accidant 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Panding invastigation 6 [ ] Could not be datarmined

28a. Data of Injury (Month, Day Year)

28b. Tima of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Dascribe how injury occurred

28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Spacify)

28f. Location (Straat and Number or Rural Routa Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Phyaician**: To the bast of my knowledge, death occurred at tha tima, data and place, and dua to the causa(s) and mannar as stated. 2 [ ] **Medical Examiner**: On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, and due to the cause(s) and mannar statad.

29b. Signeture and title of certifier: Ross E. Beckler MD

29c. Licansa number: D30496

29d. Data signad (Month, Day, Yaar): 11/13/98

30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print): Francis E. Becker MD; 300 W. 6th St, Frederick, MD 21701

State Registrar

31. Data filed (Month, Day, Yaar): NOV 13 1998

32. Registrar's Signatura: Geneva G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37047

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): George Elmer Robertson
2. Dete of Death Month Dey Year: November 22 1998
3. Time of Death: 6:10 p.m.
4e. Feciity Name (If not institution, give street end number): Egle Nursing Home
4b. City, Town, or Location of Deeth: Lonaconing
4c. County of Deeth: Allegany

Funeral Director

5. Sociel Security Number: 214-07-0703
6. Sex: 1 X M 2 ☐ F
7. Age (In yrs. last birthday): 91 Yrs.
If Under 1 Year: Months / Deys
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): January 4 1907
9. Birthplece (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Allegany
10c. City, Town or Location: Frostburg
10d. Inside City Limits: 1 ☐ Yes 2 X No
10e. Street end Number: 14405 New Georges Creek RD SW
10f. Zip Code: 21532
10g. Citizen of Whet Country?: USA
11. Maritel Status: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:
14. Race - American Indien, Black, White, etc. Specify: White
15. Decedent's Eduestion (Specify only highest grade completed): Elementary/Secondary (0-12): 8 College (1-4or 5+): 0
16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Labor
16b. Kind of Business/Industry: Tire
17. Father's Name (First, Middle, Last): George Robertson
18. Mother's Name (First, Middle, Maiden Surname): Maude Harding
19a. Informant's Name/Relationship (Type, Print): Judy Ravenscroft daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 19300 Upper Paradise Street, Frostburg, MD 21532
20a. Method of Disposition: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): St. Josephs Cemetery
Date: Nov. 25 1998
20c. Location - City or Town, State: Midland, MD
21. Signeture of Funerel Service Licensee: ▶ Jane E. McKenzie
22. Name end Address of Feeility: Eichhorn-McKenzie Funeral Home P.A. 8 E. Main Street, Lonaconing, MD 21539

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heert failure. List only one cause on eech line.

		Approximate Intervel Between Onset and Death
Immediate Ceuse (Final disease or condition resulting in death) e.	Left cerebral infarct	14 days
Due to (or es a consequence of):		
Sequentielly list conditions, if eny, leeding to immediete ceuse. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Lest b.	Congestive Heart failure	1 yr.
Due to (or es e consequence of):		
c.	Coronary Artery Disease	2 yr.
Due to (or es e consequence of):		
d.	Generalized arteriosclerosis	10 years

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.: Carcinoma Prostate

23b. **Did tobacco use contribute to the cause of death?** 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

24a. Wes en eutopsy performed? 1 ☐ Yes 2 X No

24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? 1 ☐ Yes 2 ☐ No

25. Wes case referred to medical examiner? 1 ☐ Yes 2 X No

26. Piece of Deeth (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Deeth: 1 X Neturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28e. Dete of Injury (Month, Dey Yeer):
28b. Time of Injury: M
28c. Injury et Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred:
28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify):
28f. Location (Street and Number or Rural Route Number, City or Town, State):

29a. Certifier (Check only one): 1 X **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner es steted. 2 ☐ **Medical Examiner**: On the basis of exemination and/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier: ▶ L.R. Miles, M.D.
29c. License number: D07004
29d. Date signed (Month, Day, Year): Nov. 23, 1998

30. Name end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print): L.R. MILES, JR., M.D. 57 JACKSON ST LONACONING MD. 21539

State Registrar

31. Dete filed (Month, Day, Year): NOV 24 1998
32. Registrar's Signature: ▶ Donna D. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificete be executed within 24 hours efter death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

8

TMS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: R. Anna Realey
2. Date of Death (Month, Day, Year): November 21, 1998
3. Time of Death: 9:48 PM
4a. Facility Name *(If not institution, give street and number)*: Calvert Manor Healthcare Center
4b. City, Town, or Location of Death: Rising Sun
4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 212-05-0321
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 95 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: January 28, 1903
9. Birthplace *(State or Foreign Country)*: Md.

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. Stete: Md.
10b. County: Cecil
10c. City, Town or Location: Elkton
10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 238 Mackall Street
10f. Zip Code: 21921
10g. Citizen of Whet Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Rece - American Indien, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 10 | College (1-4or 5+):
16a. Decedent's Usuei Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Operator
16b. Kind of Business/Industry: C. & P. Telephone

17. Father's Name *(First, Middle, Last)*: William H. R. Realey
18. Mother's Name *(First, Middle, Maiden Surneme)*: Edith Louise Clay

19a. Informent's Name/Relationship *(Type, Print)*: Robert L. McKeown, Jr. Nephew
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 227 Gallaher Rd., Elkton, Md. 21921

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Placa of Disposition *(Name of cemetery, crematory or other place)*: Elkton Cemetery
Date: 11/25/98
20c. Location - City or Town, State: Elkton, Md.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Gee Funeral Home 259 E. Main St., Elkton, Md. 21921

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heert failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death): e. PNEUMONIA, ASPIRATION — 12 HOURS
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immedeate cause. Enter Underlying Cause (Disease or Injury thet Initiated events resulting in death) Lest:
b.
Due to (or as e consequence of):
c.
Due to (or es a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings availeble prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Sulcide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, offica building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated. 2☐ **Medicat Examiner:** On the basis of examinetion and/or Investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D45344
29d. Date signed *(Month, Day, Year)*: 11/24/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SURESH DHANJANI, MD, 20 CRAIGTOWN RD, PERRYVILLE, MD 21903

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 24 1998
32. Registrar's Signature: Geneva B. Sparks

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Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, pege 2 should be detached for use as the burial-transit permit. Pages 1 end 2 should be filed within 72 hours efter death with the Meryland Department of Health end Mentel Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37049

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Robert John Richardson Sr.

2. Date of Death: Month November Day 21 Year 1998

3. Time of Death: 0855 A

4e. Facility Name (If not institution, give street and number): Laurelwood Center

4b. City, Town, or Location of Death: Elkton

4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 177-12-4065

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 78 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): September 13, 1920

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Cecil

10c. City, Town or Location: Elkton

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 510 Hollingsworth Avenue

10f. Zip Code: 21921

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII 1942-45

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Truck Driver

16b. Kind of Business/Industry: Automotive Industry

17. Father's Name (First, Middle, Last): George Richardson

18. Mother's Neme (First, Middle, Maiden Surname): Mary A. Courtney

19e. Informent's Name/Relationship (Type, Print): Georgie A. Johnson/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 33 Park Lane, Elkton, Maryland 21921

20e. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removel from State 4 [ ] Donetion 5 [ ] Other (Specify)

20b. Piece of Disposition (Name of cemetery, cremetory or other place): Delaware Veterans Memorial Cemetery

Date: Nov. 24 1998

20c. Location - City or Town, State: Bear, Delaware

21. Signature of Funeral Service Licensee: Donna S. Hicks

22. Name end Address of Facility: Hicks Home for Funerals, P.A. 103 West Stockton Street, Elkton, MD 21921

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset end Death

Immediate Ceuse (Finel diseese or condition resulting in deeth)
e. COPD >20yrs

Due to (or as e consequence of):
b. CAD >10yrs

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Lest

Due to (or es e consequence of):
c. Hypertension >40yrs

Due to (or as a consequence of):
d. Cerebral Vascular disea

Part tt. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Wes an eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Were eutopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Deeth (Check only one): Hospitel: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Naturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury et Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) and menner es stated. 2 [ ] Medicat Examiner: On the besis of examinetion end/or investigation, in my opinion, death occurred et the time, date end piece, end due to the cause(s) end menner stated.

29b. Signature and title of certifier: Jose Ma M.D.

29c. License number: D44716

29d. Date signed (Month, Day, Year): November 23, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jose Ma M.D. 111 E. High St, Elkton MD 21921

State Registrar

31. Date filed (Month, Day, Year): NOV 23 1998

32. Registrar's Signature: Donna S. Hicks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEMS: # 30 PER V.R. G770 4-2-99 WR.

Certificate of Death

Reg. No. 98 37650

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Louise Kirk Reed
2. Data of Daath Month Day Yaar: November 22, 1998
3. Tima of Daath: 10:55 am
4a. Facility Nama *(If not institution, giva street and number)*: Calvert Manor Healthcare Center
4b. City, Town, or Location of Daath: Rising Sun
4c. County of Daath: Cecil

Funeral Director

5. Social Security Number: 190-32-4034
6. Sax: 1☐ M 2☒ F
7. Aga *(In yrs. last birthday)*: 98 Yrs. (If Undar 1 Yaar: Months / Days; If Undar 24 Hrs.: Hours / Min.)
8. Data of Birth *(Month, Day, Yaar)*: 12/7/1899
9. Birthplaca *(State or Foraign Country)*: PA

Usual Rasidence of Dacadant

10a. Stata: MD
10b. County: Cecil
10c. City, Town or Location: Rising Sun
10d. Insida City Limits: 1☐ Yas 2☒ No
10e. Straat and Numbar: 1881 Telegraph Road
10f. Zip Coda: 21911
10g. Citizan of What Country?: USA

11. Marital Status: 1☐ Navar Marriad 2☐ Marriad 3☐ Widowad 4☒ Divorcad
12. Was Dacadant Ever in U.S. Armad Forcas? 1☐ Yas 2☒ No. If Yas, Giva Yaar or Datas:
13. Was Dacadant of Hispanic Origin? (Spacify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No *Specify:*
14. Raca - Amarican Indian, Black, Whita, atc. *Specify:* white

15. Dacadent's Education *(Specify only highest grada completad)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 4
16a. Dacadant's Usual Occupation *(Giva kind of work done during most of working life. DO NOT use retired)*: school teacher
16b. Kind of Businass/Industry: education

17. Fathar's Nama *(First, Middle, Last)*: Frank Kirk
18. Mothar's Nama *(First, Middle, Maiden Surname)*: Sara Elizabeth Crowl

19a. Informant's Name/Ralationship *(Typa, Print)*: Kirk Reed/son
19b. Mailing Address *(Street and Numbar or Rural Route Numbar, City or Town, Stata, Zip Coda)*: P.O. Box 282, Oxford, PA 19363

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*
20b. Placa of Disposition *(Nama of cematary, crematory or other placa)*: New London Presbyterian
Data: 11/27/98
20c. Location - City or Town, Stata: New London, PA

21. Signatura of Funaral Sarvica Licensaa: ▶ Kevin D. Collins
22. Nama and Address of Facility: Collins Funeral Home, Oxford, PA 19363

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complications that causad tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or hart failura. List only ona causa on aach lina.

Approximata Intarval Batwaan Onsat and Daath

Immadiata Causa (Final disaasa or condition rasulting in daath)
a. Probable acute myocardial infarction — hours

Dua to (or as a consaquanca of):

Saquantially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Disaasa or injury that initiatad avants rasulting in daath) Last
b.
Dua to (or as a consaquanca of):
c.
Dua to (or as a consaquanca of):
d.

Part II. **Othar significant conditions** contributing to daath but not rasulting in tha underlying cause givan in Part I.: Advanced alzheimers dementia

23b. Did tobacco usa contributa to tha causa of daath? 1☐ Yas 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No
24b. Were autopsy findings available prior to compliation of causa of daath? 1☐ Yas 2☐ No

25. Was casa rafarrad to medical examiner? 1☐ Yas 2☒ No
26. Placa of Daath *(Check only one)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpatiant 3☐ DOA; Othar: 4☒ Nursing Homa 5☐ Rasidanca 6☐ Othar *(Specify)*

27. Manner of Daath: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be datarminad
28a. Data of Injury *(Month, Day Yaar)*
28b. Tima of Injury M
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Describa how injury occurrad
28e. Placa of Injury - At homa, farm, straat, factory, office building, atc. *(Specify)*
28f. Location *(Street and Numbar or Rural Route Numbar, City or Town, Stata)*

29a. Certifiar *(Check only one)*: 1☒ **Certifying Physician:** To tha bast of my knowladga, daath occurrad at tha tima, data and placa, and due to the cause(s) and mannar as stated. 2☐ **Madical Examinar:** On tha basis of examination and/or invastigation, in my opinion, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar statad.

29b. Signatura and titla of certifiar: ▶ [signature]
29c. Licansa number: D44102
29d. Data signad *(Month, Day, Yaar)*: 11/23/98

30. Nama and addrass of parson who compliatad causa of daath (Item 23a) (Typa, Print): WILLIAM FERRAR RENZULLI, M.D., 901 WARBURTON ROAD, ELKTON, MD 21921

State Registrar

31. Data filad *(Month, Day, Yaar)*: NOV 23 1998
32. Ragistrar's Signatura: [signature] B. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 3705

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARGARET DELIAH ROUTZAHN
2. Data of Death Month Day Yaar: NOVEMBER 13, 1998
3. Tima of Death: 8:30 A.M.
4a. Facility Nama *(If not institution, giva street and number)*: RAVENWOOD LUTHERAN VILLAGE
4b. City, Town, or Location of Death: HAGERSTOWN
4c. County of Death: WASHINGTON

Funeral Director

5. Social Security Number: 214-09-8324
6. Sex: 1☐ M 2☒ F
7. Aga *(In yrs. last birthday)*: 82 Yrs.
If Under 1 Yaar: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Yaar)*: FEB. 5, 1916
9. Birthplaca *(Stata or Foraign Country)*: VIRGINIA

Usual Residance of Decedant

10a. State: MARYLAND
10b. County: WASHINGTON
10c. City, Town or Location: HAGERSTOWN
10d. Insida City Limits: 1☒ Yas 2☐ No
10e. Street and Numbar: 1106 LUTHER DRIVE
10f. Zip Coda: 21740
10g. Citizan of What Country?: U.S.A.

11. Marital Status: 1☐ Navar Marriad 2☐ Married 3☒ Widowad 4☐ Divorced
12. Was Dacedent Ever in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:
13. Was Dacedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 1☐ Yas 2☒ No *Specify:*
14. Race - American Indian, Black, Whita, atc. *Specify:* WHITE

15. Dacedent's Education *(Specify only highast grada complatad)*: Elementary/Secondary (0-12): 8 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT use retired)*: HOMEMAKER
16b. Kind of Businass/Industry: OWN HOME

17. Fathar's Name *(First, Middle, Last)*: JAMES KEMPER YOWELL
18. Mothar's Nama *(First, Middle, Maidan Surname)*: REBECCA ANN RITENOUR

19a. Informant's Name/Ralationship *(Typa, Print)*: FUNERAL HOME RECORDS
19b. Mailing Addrass *(Street and Number or Rural Route Number, City or Town, Stata, Zip Coda)*: 7606 OLD NATIONAL PIKE, BOONSBORO, MARYLAND 21713

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Spacify)*
20b. Placa of Disposition *(Nama of cematary, cramatory or othar placa)*: CEDAR LAWN MEMORIAL PARK
Data: 11/17/98
20c. Location - City or Town, Stata: HAGERSTOWN, MARYLAND

21. Signatura of Funaral Sarvica Licansaa: ▶ Paul M Dean
22. Nama and Address of Facility: BAST FUNERAL HOME, 7606 Old National Pike, Boonsboro, Maryland 21713

Physician /Medical Examiner

23a. Part1. Enter tha disease, or complications that causad the death. Do not antar tha moda of dying, such es cardiac or raspiratory arrast, shock, or haart failura. List only ona cause on aach lina.

Approximate Intarval Batwaan Onsat and Death

Immediata Causa (Final disaase or condition resulting in death)
a. Cardiopulmonary arrest — instant
Dua to (or as a consequence of):
b. Hypertensive cardiovascular disease — many years

Sequentially list conditions, if any, leading to immadiata causa. Entar Underlying Causa (Disease or injury that initiatad avants rasulting in death) Last
Dua to (or as a consequance of):
c.
Dua to (or as a consequance of):
d.

Part II. **Othar aignificant conditions** contributing to daath but not rasulting in tha underlying causa givan in Part I.

Old intracerebral hemorrhage into right basal ganglion with left heniplegia, previous cerebral infarction

23b. Did tobecco use contributa to the cauaa of death? 1☐ Yaa 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings available prior to complation of cause of deeth? 1☐ Yas 2☐ No

25. Was casa raferrad to medical examinar? 1☐ Yes 2☒ No

26. Piece of Death *(Check only one)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpatiant 3☐ DOA; Othar: 4☒ Nursing Homa 5☐ Rasidance 6☐ Other *(Specify)*

27. Mennar of Daath: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Pending investigation 6☐ Could not ba datarminad

28a. Date of Injury *(Month, Day Yaar)*
28b. Tima of Injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurrad
28e. Piece of Injury - At homa, farm, straat, factory, offica building, atc. *(Spacify)*
28f. Location *(Straat and Number or Rural Route Numbar, City or Town, Stata)*

29a. Certifiar *(Check only one)*: 1☒ **Cartifying Physician:** To tha best of my knowladga, daath occurrad at tha tima, data and placa, and dua to tha cause(s) and mannar as stated. 2☐ **Madical Examinar:** On tha basis of axamination and/or invastigation, in my opinion, death occurrad at tha time, date and placa, and due to tha cause(s) and mannar stated.

29b. Signatura and titla of certifiar: ▶ Edson Moody M.D.
29c. License numbar: D07857
29d. Data signad *(Month, Day, Yaar)*: NOVEMBER 23,1998

30. Nama and address of parson who complatad cause of death (Item 23a) (Type, Print): Edson B. Moody, M.D., 1190 Mt. Aetna Road, Hagerstown, MD 21740

State Registrar

31. Data filad *(Month, Day, Yaar)*: NOV 23 1998
32. Registrar's Signature: ▶ Penni G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37052

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Wayne Eugene Rizer

2. Date of Death — Month: Nov. Day: 12, Year: 1998

3. Time of Death: 4:15PM

4a. Facility Name *(If not institution, give street and number)*: 11320 Lakeside Drive

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 172-26-8840

6. Sex: 1☒M 2☐F

7. Age *(In yrs. last birthday)*: 65 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Dec.14,1932

9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 11320 Lakeside Drive

10f. Zip Code: 21740

10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates: 2/26/53 12/22/54

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Machinist

16b. Kind of Business/Industry: Aircraft Manufacturing

17. Father's Name *(First, Middle, Last)*: Eugene R. Rizer

18. Mother's Name *(First, Middle, Maiden Surname)*: Mary E. Shaffer

19a. Informant's Name/Relationship *(Type, Print)*: Ella Mae Rizer/Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 11320 Lakeside Drive,Lot 30, Hagerstown,MD 21740

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donetion 5☐Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Rest Haven Cemetery — Date: Nov.16,1998

20c. Location - City or Town, State: Hagerstown,Maryland

21. Signature of Funeral Service Licensee: Kelly E. Hanke

22. Name and Address of Facility: Douglas A. Fiery Funeral HOme 1331 Eastern Blvd.,N.,Hagerstown,Maryland 21742

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) a. lung cancer. — 18months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒Yes 2☐No 3☐Probably 4☐Unknown

24a. Was en autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of ceuse of death? 1☐Yes 2☐No

25. Was cese referred to medicel examiner? 1☐Yes 2☒No

26. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA — Other: 4☐Nursing Home 5☒Residence 6☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Allan D. Hoffman MD

29c. License number: D26806

29d. Date signed *(Month, Day, Year)*: 11/13/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Allan D. Hoffman MD 747 Northern Ave Hagerstown MD 21742

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 13 1998

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98-37053

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Thelma Geneva ROE

2. Date of Death — Month: 11 Day: 11 Year: 98

3. Time of Death: 7:05PM

4a. Facility Name *(If not institution, give street end number)*: Ravenwood Lutheran Village Nursing Care Center

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 219-07-3874

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 89 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Dey, Year)*: Nov. 9, 1909

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 18025 Putter Drive

10f. Zip Code: 21740

10g. Citizen of Whet Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorcad

12. Wes Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decadent's Education *(Specify only highest grede completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: owner/operator

16b. Kind of Business/Industry: retail sales

17. Fether's Neme *(First, Middle, Last)*: Robert F. Fouke

18. Mother's Name *(First, Middle, Maiden Surname)*: Maude B.

19a. Informent's Name/Relationship *(Type, Print)*: Massey H. Roe - husband

19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 18025 Putter Dr., Hagerstown, Md. 21740

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other place)*: Rest Haven Cemetery — Date: 11-16-98

20c. Location - City or Town, State: Hagerstown,Maryland

21. Signature of Funeral Service Licensee: Scott M Kennedy

22. Name and Address of Fecility: MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown,Md. 21740

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions thet caused the death. Do not enter the mode of dying, such es cerdiac or respiratory errest, shock, or heart failure. List only one cause on eech line.

Approximete Interval Between Onset end Deeth

Immediate Cause (Finel disease or condition resulting in death) e. Ovarian Cancer with Metastasis — 8 years

Due to (or as e consequenca of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in deeth) Lest

b. Due to (or es e consequence of):

c. Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uee contribute to the cauee of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveileble prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Piece of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residenca 6☐ Other *(Specify)*

27. Manner of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Yeer)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, offica building, etc. *(Specify)*

28f. Location *(Street and Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the besis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end placa, end due to the ceuse(s) end menner stated.

29b. Signeture and title of certifier: Samuel Chan

29c. License number: D36655

29d. Date signed *(Month, Dey, Yeer)*: Nov. 13, 1998

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print): 1185 MT. AETNA RD. HAGERSTOWN, MD 21740

State Registrar

31. Dete filed *(Month, Day, Year)*: NOV 13 1998

32. Registrar's Signeture: B. Sparks

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Peges 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours efter death.

To the Funerel Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Division of Vital Records, P.O. Box 68760,

ROE, THELMA Genevera

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37054

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
Flora	Elizabeth	SCHWEARING	November 20, 1998	6:00 pm

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Homewood Retirement Center of Frederick	Frederick	Frederick

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-10-1105	1☐ M 2☒ F	83 Yrs.			Dec 2,1914	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Frederick	Frederick	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
31 West Patrick Street	21701	U.S.A.

11. Maritel Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - Americen Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondary (0-12)	College (1-4or 5+)		
11		Sales Associate	Retail Dept Store

17. Fether's Neme (First, Middle, Last)			18. Mother's Name (First, Middle, Meiden Surneme)		
Charels	R.	GAVER	Mary	M	Wiles

19a. Informent's Name/Relationship (Type, Print)	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)
Mrs. LaRue Hammond/Daughter	13531 Donnybrook Drive, Hagerstown, MD 21742

20a. Method of Disposition	20b. Place of Disposition (Neme of cemetery, cremetory or other piece)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Mt Olivet Cemetery	Nov 24,1998	Frederick, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature] M00706	Keeney & Basford P.A. Funeral Home 106 East Church St, Frederick, Maryland 21701

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on eech line.

Approximate Intervel Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death)
a. Pneumonitis.

Due to (or as a consequence of):
b. Dementia Alzheimers

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were eutopsy findings available prior to completion of ceuse of death?
1☐ Yes 2☑ No	1☐ Yes 2☐ No NA

25. Was cese referred to medicel examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☑ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined	—	M	1☐ Yes 2☐ No	

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street end Number or Rural Route Number, City or Town, State)
—	—

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner es steted.
2☐ **Medical Examiner:** On the basis of examination and/or Investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

29b. Signature end title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature] MD	D 18063	11/23/98

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
ABDUL MAJEED 801 TOLL HOUSE AVE FREDERICK MD 21701

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 23 1998	▶ Geneva B. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37055

Amended Items#28a-c perPhyG774 8/25/99 EW

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
Louise M. Sherman	November 20, 1998	6:04 P.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Frederick Memorial Hospital	Frederick	Frederick

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
579-10-2820	1☐ M 2☒ F	89 Yrs.			Nov. 30, 1908	Washington, DC

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Frederick	Mt. Airy	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
4701 Cowmans Court South	21771	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10		Dept of Labor	Federal Government

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Pietro Episcopo	Margaret Stevens

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Cheryl Windsor, granddaughter	4701 Cowmans Court South, Mt. Airy, MD 21771

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Buriel 2☐ Cremation 3☐ Removel from State 4☐ Donation 5☐ Other (Specify)	Cedar Hill Cemetery	11/24/98	Suitland, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
[signature]	Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, MD 21702

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line.

		Approximate Interval Between Onset and Death
Immediate Ceuse (Final disease or condition resulting in death)	a. Cardiogenic shock	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Dilated Cardiomyopathy	
	Due to (or as a consequence of):	
	c. Coronary artery disease	
	Due to (or as a consequence of):	
	d. Hypertension	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

Hypothyroidism
Hyponatremia
Herpes Zoster

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of ceuse of death?
1☐ Yes 2☑ No	1☐ Yes 2☐ No N/A

25. Was cese referred to medical examiner?	26. Place of Death (Check only one)						
1☐ Yes 2☑ No	Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)					

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined	11/20/98	18.04 M	1☐ Yes 2☐ No	—

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
—	—

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete and place, and due to the cause(s) end menner es steted.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
[signature]	D51643	11/20/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Shah Hiren, 170 Thomas Jhonson Drive Frederick MD 21702

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 24 1998	[signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 90 37650

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Stanley Cornelius STALEY
2. Date of Death Month Dey Yeer: November 17, 1998
3. Time of Death: 12:50 P.M.
4a. Facility Name *(If not institution, give street and number)*: Glade Valley Nursing Center
4b. City, Town, or Location of Death: Walkersville
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 214-10-4870
6. Sex: 1☒M 2☐F
7. Age *(In yrs. last birthday)*: 92 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Feb. 18, 1906
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street end Number: 904 Rosemont Avenue
10f. Zip Code: 21701
10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Wes Decedent Ever in U,S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.): 1☐Yes 2☒No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grede completed)*: Elementary/Secondary (0-12): 6 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Office Manager
16b. Kind of Business/Industry: Telegraph Company

17. Fether's Name *(First, Middle, Last)*: Marion Justice STALEY
18. Mother's Name *(First, Middle, Maiden Surname)*: Corilla KEYSER

19a. Informant's Name/Reletionship *(Type, Print)*: F. Stewart Cashour, Cousin
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 9008 Walnut Street, Rt2, Union Bridge, MD 21791

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donetion 5☐Other *(Specify)*
20b. Place of Disposition *(Neme of cemetery, crematory or other piece)*: Fairmont Cemetery, Nov.20,1998 — Date
20c. Location - City or Town, State: Libertytown, Maryland

21. Signature of Funeral Service Licensee: ▶ Allan H Ruby M00703
22. Name end Address of Facility: Keeney & Basford P.A. Funeral Home 106 East Church Street, Frederick, MD 21701

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Pneumonia — Due to (or as e consequence of): — 2days

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest:
b. — Due to (or es e consequence of):
c. — Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.: Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an eutopsy performed? 1☐Yes 2☒No
24b. Were eutopsy findings eveilable prior to completion of cause of death? 1☐Yes 2☐No

25. Was cese referred to medical examiner? 1☐Yes 2☒No

26. Piece of Death *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpetient 3☐DOA — Other: 4☒Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Manner of Deeth: 1☒Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury et Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physicien:** To the best of my knowledge, death occurred et the time, date end piece, end due to the ceuse(s) end manner as steted. 2☐**Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) and manner stated.

29b. Signature end title of certifier: ▶ Casper E. Cline III M.D.
29c. License number: D16428
29d. Date signed *(Month, Dey, Yeer)*: 11/17/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Casper E. Cline, III, M.D., 300 West Ninth Street, Frederick, MD 21701

State Registrar

31. Date filed *(Month, Dey, Yeer)*: NOV 18 1998
32. Registrar's Signature: ▶ Jeanne G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Peges 1 end 2 should be filed within 72 hours efter death with the Meryland Department of Health end Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificete be executed within 24 hours efter death.
To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use es the buriel-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEM #20b PER FH G774 8/26/99 AH

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Dewey Leonard Sigler, Jr.

2. Date of Death Month Dey Yeer: November 12 1998

3. Time of Death: 3:10 pm

4a. Facility Name *(If not institution, give street and number)*: 708 Second Avenue

4b. City, Town, or Location of Death: Brunswick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 214-28-0252

6. Sex: 1☒ M 2☐ F

7. Age *(in yrs. last birthday)*: 69 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: July 11 1929

9. Birthplace *(State or Foreign Country)*: Brunswick MD

Usual Residence of Decedent

10a. State: MD

10b. County: Frederick

10c. City, Town or Location: Brunswick

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 708 Second Avenue

10f. Zip Code: 21716

10g. Citizen of Whet Country?: USA

11. Maritel Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? ☒Yes 2☐ No If Yes, Give Yeer or Detes: Korean

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - Americen Indian, Bleck, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 7 / College (1-4or 5+):

16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Bricklayer

16b. Kind of Business/Industry: Construction

17. Fether's Name *(First, Middle, Last)*: Dewey Leonard Sigler, Sr.

18. Mother's Neme *(First, Middle, Maidan Surname)*: Tressie Myrtle Stonebergen

19a. Informant's Neme/Relationship *(Type, Print)*: Esther J. Sigler

19b. Mailing Address *(Street and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda)*: 708 Second Avenue, Brunswick, MD 21716

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Resthaven Memorial Gardens

Date: 11/17/99

20c. Location - City or Town, State: Frederick, MD

21. Signature of Funeral Service Licensee: Barbara A. Williams

Barbara A. Williams, Owner

22. Name and Address of Facility: John T. Williams Funeral Home 100 Petensville Rd Brunswick MD 21716

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet ceused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shcck, or heart feilure. List only one ceuse on eech line.

Approximate Intervel Between Onset end Deeth

Immediete Ceuse (Finel diseese or condition resulting in death): e. Cerebral edema — 3 wks

Due to (or es e consequence of):

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury thet initiated events resulting in deeth) Lest:

b. extensive lymphoma (CNS) 6 y-s

Due to (or es e consequence of):

c.

Due to (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.: COPD

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Wes cese referred to medical exeminer? 1☐ Yes 2☒ No

26. Plece of Deeth *(Check only one)*: Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Plece of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, dete end place, and due to the ceuse(s) end menner stated.

29b. Signature end title of certifier

29c. License number: D14625

29d. Date signed *(Month, Day, Yaar)*: Nov 16, 1998

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print): P. Gregory Rausch MD 501 West Seventh St., Frederick, Maryland 21701

State Registrar

31. Dete filed *(Month, Day, Year)*: NOV 17 1998

32. Registrar's Signature: Benjamin G. Sparks

Baltimore, Maryland 21215-0020

permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37038

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lloyd Bunkett Spence

2. Date of Death (Month, Day, Year): November 12 1998

3. Time of Death: 1:40 pm

4a. Facility Name (If not institution, give street and number): 114 Fifth Avenue

4b. City, Town, or Location of Death: Brunswick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 227-24-2992

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 80 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov 12 1918

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: MD

10b. County: Frederick

10c. City, Town or Location: Brunswick

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 114 Fifth Avenue

10f. Zip Code: 21716

10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 9

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Engineer

16b. Kind of Business/Industry: B&O Railroad

17. Father's Name (First, Middle, Last): James Joshua Spence

18. Mother's Name (First, Middle, Maiden Surname): Minnie Belle Pruitt

19a. Informent's Name/Relationship (Type, Print): Thelma V. Spence, Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 114 Fifth Avenue Brunswick MD 21716

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): Union Cemetery

Date: 11/16

20c. Location - City or Town, State: Lovettsville VA

21. Signature of Funeral Service Licensee: Barbara A. Williams

Barbara A. Williams, Owner

22. Name and Address of Facility: John T. Williams Funeral Home 100 Petersville Rd Brunswick MD 21716

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. extensive Bladder cancer — 4 mo

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

prostate ca, ASCVD, h/o Myocardial Infarction

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury: M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: 21402

29d. Date signed (Month, Day, Year): Nov 16, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

P. Gregory Rausch MD 501 West Seventh St. Frederick, Maryland 21701

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): NOV 17 1998

32. Registrar's Signature: P. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 037059

Physician /Medical Examiner

1. Decedent's Nema *(First, Middle, Last)*: Eldred Jennings Shank
2. Date of Deeth Month / Day / Year: November 12 1998
3. Time of Deeth: 1:30pm
4a. Facility Name *(If not institution, giva street and number)*: College View Center
4b. City, Town, or Location of Death: Frederick
4c. County of Deeth: Frederick

Funeral Director

5. Social Security Numbar: 216-14-6880
6. Sax: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 88 Yrs. — If Under 1 Yaar: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Sept 16 1910
9. Birthplace *(State or Foraign Country)*: Brunswick MD

Usual Residance of Decedent

10a. Stata: MD
10b. County: Frederick
10c. City, Town or Location: Jefferson
10d. Insida City Limits: 1☑ Yes 2☐ No
10e. Street end Number: 3405 Livingston Drive
10f. Zip Code: 21755
10g. Citizen of Whet Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Giva Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Spacify:*
14. Race - American Indian, Bleck, White, etc. *Specify:* White

15. Decedent's Educetion *(Spacify only highest grede complated)*: Elementary/Secondary (0-12): 12 — Collaga (1-4or 5+):
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working lifa. DO NOT use retired)*: Manager
16b. Kind of Businass/Industry: Sears Stone

17. Fether's Name *(First, Middle, Last)*: Charles E. Jennings
18. Mother's Name *(First, Middle, Maiden Surneme)*: Edith E. Russell

19a. Informent's Name/Relationship *(Type, Print)*: Nancy S. Smith
19b. Mailing Address *(Street end Number or Rurel Routa Number, City or Town, Stete, Zip Code)*: 3405 Livingston Dr., Jefferson, MD 21755

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Nama of cematery, crematory or other place)*: Park Heights Cemetery
Date: 11/15
20c. Location - City or Town, State: Brunswick, MD

21. Signature of Funeral Service Licensee: Barbara A. Williams
Barbara A. Williams, Owner
22. Name and Address of Facility: John T. Williams Funeral Home 100 Petersville Rd Brunswick MD 21716

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Pert1. Enlar the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one cause on eech lina.

Approximate Intervel Batwaan Onsat and Deeth

Immediate Cause (Final disease or condition resulting In deeth)
a. malnutrition
Due to (or as a consequence of):
b. anorexia
Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Causa (Disaase or injury that initiated events resulting In daath) Last
Dua to (or as a consequence of):
c. chronic gastritis
Due to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceusa givan in Part I.: Chronic obstructive lung disease

23b. **Did tobacco usa contributa to the cause of death?** 1☐ **Yes** 2☒ **No** 3☐ **Probably** 4☐ **Unknown**

24a. Wes en autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings aveilable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was cese referred to medicel examiner? 1☐ Yes 2☒ No

26. Plece of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Othar: 4☒ Nursing Home 5☐ Residence 6☐ Othar *(Specify)*

27. Manner of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*
28b. Time of Injury
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, atc. *(Specify)*
28f. Location *(Street and Number or Rurel Routa Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the tima, data and place, and dua to tha ceusa(s) and mannar es stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the ceusa(s) and manner stated.

29b. Signature end titla of certifier: W. Mlgan MD
29c. License number: D16675
29d. Date signed *(Month, Dey, Yeer)*: 12/13/98

30. Nama and address of person who completed causa of death (Item 23e) (Type, Print): WAYNE ALGHER, BRUNSWICK, MD 21716

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Deta filed *(Month, Day, Year)*: NOV 19 1998
32. Registrar's Signature: Penny B. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEMS 28a-28f PER ME G774 8/26/99 AH

Certificate of Death

Reg. No. 98-37060

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Robert Alan SPRINGER
2. Dete of Deeth: Month November Day 11 Year 1998
3. Time of Death: 7:43 pm
4e. Feciity Neme (If not institution, give street end number): Frederick Memorial Hospital
4b. City, Town, or Location of Deeth: Frederick
4c. County of Deeth: Frederick

Funeral Director

5. Social Security Number: 217-84-4239
6. Sex: 1☒M 2☐F
7. Age (In yrs. last birthday): 35 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Yeer): Aug 7, 1963
9. Birthplece (State or Foreign Country): Maryland

Usuel Residence of Decedent

10a. Stete: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street end Number: 6419 Quinn Road
10f. Zip Code: 21701
10g. Citizen of Whet Country?: U.S.A.
11. Maritel Status: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Rece - Americen Indien, Bleck, White, etc. Specify: White
15. Decedent's Education (Specify only highest grede completed): Elementery/Secondary (0-12): 12 / College (1-4or 5+):
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Never Worked
16b. Kind of Business/Industry:
17. Father's Neme (First, Middle, Last): James Edward SPRINGER
18. Mother's Name (First, Middle, Meiden Surneme): Sylvia LaRue HART
19a. Informent's Name/Relationship (Type, Print): Mrs. Sylvia L. Springer/Mother
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 6419 Quinn Road, Frederick, Maryland 21701
20e. Method of Disposition: 1☒Burial 2☐Cremetion 3☐Removel from State 4☐Donation 5☐Other (Specify)
20b. Piece of Disposition (Neme of cemetery, crematory or other place): Frederick Memorial Park
Dete: Nov 14,1998
20c. Location - City or Town, State: Frederick, Maryland
21. Signature of Funeral Service Licensee: Kathlynn Roberson M00706
22. Name end Address of Feciity: Keeney & Basford P.A. Funeral Home 106 E Church Street, Frederick, Maryland 21701

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on eech line.

Approximete Intervel Between Onset end Death

Immediate Ceuse (Final diseese or condition resulting in deeth)
a. **Aspiration Pneumonia** — Days

Due to (or es e consequence of):
b. **Propoxyphene Napsylate Overdose** (Darvocet) — **9 days**

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Wes an eutopsy performed? 1☐Yes 2☒No
24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1☐Yes 2☐No

25. Wes case referred to medical exeminer? 1☒Yes 2☐No
26. Piece of Death (Check only one): Hospital: 1☒Inpetient 2☐ER/Outpetient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)
27. Manner of Deeth: 1☐Neturel 2☐Accident 3☒Suicide 4☐Homicide 5☐Pending Investigation 6☐Could not be determined
28a. Date of Injury (Month, Dey Yeer): NOVEMBER2,1998
28b. Time of Injury: 11:24 am M
28c. Injury et Work? 1☐Yes 2☒No
28d. Describe how injury occurred: DRUG OVERDOSE
28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify): 6419 Quinn RD., FREDERICK,MD
28f. Location (Street end Number or Rural Route Number, City or Town, Stete): HOME
29a. Certifier (Check only one): 1☐Certifying Physician: To the best of my knowledge, death occurred et the time, date end piece, end due to the cause(s) end menner es steted. 2☒Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and placa, end due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: D35164
29d. Date signed (Month, Dey, Yeer): November 12, 1998
30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print): Andrew Zarick, Jr, M.D., 1080 West Patrick Street, Frederick, Maryland 21703

State Registrar

31. Date filed (Month, Dey, Yeer): NOV 13 1998
32. Registrar's Signeture:

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'natural', or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37061

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last)			2. Dete of Deeth Month / Day / Year	3. Time of Death
Doris	Rebecca	STONE	October 31, 1998	8:45 P.M.

4e Fecility Neme (If not institution, give street end number)	4b. City, Town, or Location of Deeth	4c. County of Deeth
8388 Dream Place	Walkersville	Frederick

Funeral Director

5. Sociel Security Number	6. Sex	7. Age (In yrs. lest birthdey)	If Under 1 Year: Months / Deys	If Under 24 Hrs.: Hours / Min.	8. Dete of Birth (Month, Dey, Yeer)	9. Birthplece (Stete or Foreign Country)
214-10-1685	1☐ M 2☒ F	64 Yrs.			Jan. 21, 1934	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Frederick	Walkersville	1☐ Yes 2☒ No

10e. Street end Number	10f. Zip Code	10g. Citizen of Whet Country?
8388 Dream Place	21793	U.S.A.

11. Maritel Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indien, Bleck, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Detes:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Eduction (Specify only highest grade completed)		16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elemantary/Secondary (0-12)	Collega (1-4or 5+)		
11		Homemaker	Own Home

17. Father's Neme (First, Middle, Last)	18. Mother's Neme (First, Middle, Maiden Surnama)
Grayson Winfield Phelps	Mary Hardman

19a. Informent's Name/Reletionship (Type, Print)	19b. Mailing Addrass (Streat and Numbar or Rurel Route Number, City or Town, Stata, Zip Coda)
Charles S. Stone/Husband	8388 Dream Place, Walkersville, MD 21793

20e. Method of Disposition	20b. Place of Disposition (Nama of cemetery, cremetory or other place)	Dete	20c. Location - City or Town, Stete
1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)	Resthaven Memorial Gardens	Nov. 3, 1998	Frederick, MD

21. Signature of Funeral Service Licensee	22. Name end Address of Feclility
Richard C.L. Basford MD0021	Keeney and Basford Funeral Home 106 East Church Street, Frederick, MD 21701

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heart failure. List only one ceuse on each line.

Approximete Intervel Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death)
e. EXTENSIVE UBE-IVE SYNCOPE 12 MO

Due to (or es e consequence of):

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Causa (Disaasa or Injury that initiated events resulting in deeth) Lest
b.

Due to (or as e consequanca of):

c.

Due to (or es e consequence of):

d.

Pert II. **Other significant conditione** contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was en eutopsy performed?	24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was casa raferred to medicel exeminer?	26. Piece of Deeth (Check only ona)
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Mannar of Daath	28e. Dete of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Piece of Injury - At home, farm, streat, factory, office building, etc. (Specify)			28f. Location (Streat end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one)
1☐ **Certifying Physician**: To the best of my knowledge, death occurred et the time, dete end piece, end due to the ceuse(s) end mennar as statad.
2☒ **Medical Examiner**: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to tha ceuse(s) end menner stated.

29b. Signeture end title of certifiar	29c. License number	29d. Date signed (Month, Dey, Year)
	D14C 2C	Nov 2, 1998

30. Neme end eddress of person who completed cause of death (Item 23a) (Typa, Print)
P. Gregory Rausch MD 501 West Seventh St., Frederick, Maryland 21701

State Registrar

31. Date filed (Month, Dey, Yeer)	32. Registrar's Signature
NOV 02 1998	B. Bowers

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37062

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Lest)*: AGNES BELINDA SCHROCK

2. Dete of Deeth — Month: NOVEMBER Dey: 20, Year: 1998

3. Time of Deeth: 7:40 PM

4e. Feclity Neme *(If not institution, give street end number)*: DEVLIN MANOR NURSING HOME

4b. City, Town, or Location of Deeth: CUMBERLAND

4c. County of Deeth: ALLEGANY

Funeral Director

5. Sociel Security Number: 196-18-0349

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. lest birthday)*: 84 Yrs. — If Under 1 Year: Months / Deys; If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Dey, Year)*: Feb 17, 1914

9. Birthplace *(State or Foreign Country)*: Pennsylvania

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: PA

10b. County: SOMERSET

10c. City, Town or Location: SALISBURY

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: GAY STREET

10f. Zip Code: 15558

10g. Citizen of What Country?: USA

11. Marital Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - Americen Indien, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grede completed)*: Elementary/Secondary (0-12): 9 th; College (1-4or 5+):

16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: PRESSER

16b. Kind of Business/Industry: DRY CLEANING

17. Fether's Neme *(First, Middle, Last)*: HARVEY MILLER

18. Mother's Name *(First, Middle, Maiden Sumame)*: BELINDA BAER

19a. Informent's Name/Reletionship *(Type, Print)*: LOIS J. CAIN/DAUGHTER

19b. Meiling Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 513 MEMORIAL AVE., CUMBERLAND, MD 21502

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Pleca of Disposition *(Name of cemetery, cremetory or other place)*: GREENVILLE CEM. Date: NOV. 23, 1998

20c. Location - City or Town, Stete: MEYERSDALE, PA

21. Signeture of Funeral Service Licensee: D Lee Newman

22. Name end Address of Fecility: NEWMAN Funeral Homes, P.A., P.O. Box 275 179 Miller St., Grantsville, MD 21536

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23e. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on eech line.

Approximete Intervel Between Onset end Deeth

Immediate Ceuse (Final disease or condition resulting in death)
e. Acute Myocardial Infarction — 30 min

Due to (or es a consequence of):
b. Coronary Artery Dis — years

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in deeth) Last
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Piece of Death *(Check only one)*: Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Deeth: 1☐ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Pleca of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, dete end piece, end due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier: Anthony J. Bollino, Jr. M.D.

29c. License number: D17565

29d. Date signed *(Month, Dey, Year)*: Nov. 23, 1998

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print): ANTHONY J. BOLLINO, JR., M.D.-922 NATIONAL HIGHWAY, LAVALE, MD 21502

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 24 1998

32. Registrer's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Peges 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health end Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

2

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37063

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Edith Caldwell SCHELL

2. Date of Death — Month: November Day: 18 Year: 1998

3. Time of Death: 12:30 PM

4a. Facility Name *(If not institution, give street and number)*: Goodwill Mennonite Home

4b. City, Town, or Location of Death: Grantsville

4c. County of Death: Garrett

Funeral Director

5. Social Security Number: 219-14-7025

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 100 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Nov. 26, 1897

9. Birthplace *(State or Foreign Country)*: West Virginia

Usual Residence of Decedent

10a. State: MD

10b. County: Garrett

10c. City, Town or Location: Oakland

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: Star Rt. 1, Box 105

10f. Zip Code: 21550

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10th — College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Housewife

16b. Kind of Business/Industry: Home

17. Father's Name *(First, Middle, Last)*: William Kelly

18. Mother's Name *(First, Middle, Maiden Surname)*: Martha ----- (Unknown)

19a. Informant's Name/Relationship *(Type, Print)*: Mary E. Lear/Daughter-in-law

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6614 Carroll Highlands Road, Eldersburg, MD 21784

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Bayard Cemetery

Date: 11/20/98

20c. Location - City or Town, State: Bayard, WV

21. Signature of Funeral Service Licensee: ▶ Bradley W. Ward

22. Name and Address of Facility: Stewart Funeral Home, 32 S. Second St., Oakland, MD 21550

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) a. Uremia — 2 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus.

Renal Insufficiency -

Organic Brain Syndrome.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ S. Chang M.D.

29c. License number: D25638

29d. Date signed *(Month, Day, Year)*: November 18, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SATURNINA CHANG M.D. Rt 36 Frostburg plaza Frostburg Maryland 21532

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 20 1998

32. Registrar's Signature: ▶ Donna G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

2

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37064

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Richard William Sauer
2. Dete of Deeth — Month: November Dey: 17 Yeer: 1998
3. Time of Deeth: 1730
4a. Fecility Neme *(If not institution, give street and number)*: Scenic pulloff, roadside, 219 North
4b. City, Town, or Location of Deeth: Accident
4c. County of Deeth: Garrett

Funeral Director

5. Social Security Number: 029-46-7974
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: Yrs. 38 — If Under 1 Yeer: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Dey, Yeer)*: Nov. 28, 1960
9. Birthplece *(State or Foreign Country)*: Germany

Usuel Residence of Decedenf

10a. Stete: Maryland
10b. County: Howard
10c. City, Town or Location: Clarksville
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street end Number: 6448 Erin Drive
10f. Zip Code: 21044
10g. Citizen of Whet Countfry?: USA
11. Merifel Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Wes Decedenf of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - Americen Indian, Bleck, White, etc. *Specify:* White
15. Decedenf's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+): 2
16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Sales Manager
16b. Kind of Business/Industry: Russell William LTD
17. Fether's Name *(First, Middle, Last)*: Jack Lloyd Sauer
18. Mother's Name *(First, Middle, Maiden Surneme)*: JoAnn (Walton) Sauer
19a. Informanf's Name/Relationship *(Type, Print)*: Frances H. Sauer, Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6448 Erin Drive, Clarksville, MD 21029
20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other piece)*: Columbia Memorial Park,
Date: Nov.20,1998
20c. Location - City or Town, State: Clarksville, MD
21. Signeture of Funeral Service Licensee: Ruth K. Newman
22. Name end Address of Fecility: Newman Funeral Homes, P.A. 179 Miller St., PO Box 275, Grantsville, MD 21536

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications thet ceused the death. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heart feilure. List only one ceuse on eech line.

Approximete Interval Between Onset end Death

Immediete Cause (Final diseese or condition resulting in death)
e. Massive Head Trauma Secondary — Immediate

Due to (or es e consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Lest
b. Gunshot Wound to Head Result of Suicide

Due to (or es e consequence of):
c.

Due fo (or es e consequence of):
d.

Part II. **Other eignificant conditions** confributing to death but not resulting in the underlying ceuse given in Pert I.

23b. Did tobecco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24e. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? 1 [ ] Yes 2 [ ] No

25. Wes cese referred to medical exeminer? 1 [X] Yes 2 [ ] No

26. Plece of Deeth *(Check only one)*: Hospitel: 1 [ ] Inpetient 2 [ ] ER/Outpetient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other *(Specify)* Roadside

27. Menner of Deeth: 1 [ ] Neturel 2 [ ] Accidenf 3 [X] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28e. Date of Injury *(Month, Dey Yeer)*
28b. Time of Injury M
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physicien:** To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es stated. 2 [X] **Medicel Examiner:** On the besis of examination end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end menner stated.

29b. Signeture and title of certifier: Paul Daniel Miller DO
29c. License number: H26154
29d. Date signed *(Month, Day, Year)*: November 18, 1998
30. Name end address of person who completed ceuse of deeth (Item 23e) (Type, Print): Paul Daniel Miller, DOPA, 69 Wolf Acres Drive, Oakland, MD 21550

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 19 1998
32. Registrar's Signature: Jenna G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours efter death with the Merylend Department of Health end Mental Hygiene. **Important: If item 27 is merkic other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

15

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37065

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Winfred Wilson Snyder, Jr.

2. Date of Death (Month, Day, Year): November 17, 1998

3. Time of Death: 0150

4a. Facility Name *(If not institution, give street and number)*: Harford Memorial Hospital

4b. City, Town, or Location of Death: Havre de Grace

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 235-30-5512

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 74 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Nov. 17, 1924

9. Birthplace *(State or Foreign Country)*: West Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Cecil

10c. City, Town or Location: Colora

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 56 Corn Cake Row

10f. Zip Code: 21917

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 1943-66

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): — College (1-4or 5+): Two Years

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Master Chief Radioman

16b. Kind of Business/Industry: U.S. Navy

17. Father's Name *(First, Middle, Last)*: Winfred Wilson Snyder, Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Flossie Pearl Payne

19a. Informant's Name/Relationship *(Type, Print)*: Mary B. Snyder (wife)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 56 Corn Cake Row, P.O. Box 3, Colora, Maryland 21917

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Bel Air Memorial Gardens — Date: 11/20/98

20c. Location - City or Town, State: Bel Air, Maryland

21. Signature of Funeral Service Licensee: ▶ Thomas M. Patterson, Sr.

22. Name and Address of Facility: Lee A. Patterson & Son Funeral Home, Perryville, Maryland 21903-0188

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. intracranial hemorrhage

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: hypertension

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*: Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)* — 28b. Time of Injury — M — 28c. Injury at Work? 1 ☐ Yes 2 ☐ No — 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)* — 28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Henry Sanborn

29c. License number: D37364

29d. Date signed *(Month, Day, Year)*: November 17, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 19 Walnut Lane, Aberdeen, Maryland

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

Snyder, Winfred Wilson Jr. 11/17/98 0150 Lmm

10+1VA

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 19 1998

32. Registrar's Signature: Barbara B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98-37066

Physician /Medical Examiner

1. Decadant's Nama *(First, Middle, Last)*: Margaret Walls Shepherd
2. Dete of Deeth — Month: Nov. — Dey: 16, — Yeer: 1998
3. Tima of Daath: 11:25p.m.
4a. Facility Nama *(If not institution, giva straat and number)*: Chestertown Nursing & Rehab. Center
4b. City, Town, or Location of Daath: Chestertown
4c. County of Deeth: Kent

Funeral Director

5. Social Security Number: 084-03-4786
6. Sax: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 99 Yrs. — If Under 1 Yaar: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Yaar)*: Aug. 22, 1899
9. Birthplaca *(State or Foreign Country)*: Maryland

Usual Rasidance of Dacedant

10a. Stata: Maryland
10b. County: Kent
10c. City, Town or Location: Chestertown
10d. Insida City Limits: 1☒ Yas 2☐ No
10a. Street and Numbar: 415 Morgnec Road
10f. Zip Coda: 21620
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Navar Marriad 2☐ Married 3☒ Widowed 4☐ Divorcad
12. Was Dacadant Evar in U.S. Armad Forces? 1☐ Yas 2☒ No — If Yas, Giva Year or Detas:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexicen, Puerto Rican, atc.) 1☐ Yas 2☒ No *Spacify:*
14. Race - Amarican Indian, Black, Whita, atc. *Specify:* White

15. Decedent's Education *(Specify only highast grada complatad)*: Elementary/Secondery (0-12): 8 — College (1-4or 5+):
16a. Dacedent's Usual Occupation *(Giva kind of work done during most of working life. DO NOT usa ratired)*: Sales Rep.
16b. Kind of Businass/Industry: Cosmetics

17. Fathar's Nama *(First, Middle, Lest)*: John Walls
18. Mothar's Nama *(First, Middle, Maidan Surname)*: Ella Bennett Walls

19a. Informant's Name/Ralationship *(Type, Print)*: Donald Walls/Nephew
19b. Mailing Addrass *(Straat and Number or Rural Routa Number, City or Town, State, Zip Code)*: 711 John Brown Road, Centreville, MD 21617

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*
20b. Place of Disposition *(Nama of cematary, crematory or othar placa)*: Church Hill Cemetery
Data: 11/19/98
20c. Location - City or Town, Stata: Church Hill, MD

21. Signature of Funeral Service Licensee: Kirk A. Helfenbein
22. Name and Address of Facility: Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, MD 21620

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused tha daath. Do not antar the mode of dying, such es cardiac or raspiratory arrast, shock, or heart failure. List only one cause on aach line. — Approximata tnterval Batween Onsat and Daath

Immadiata Cause (Final disease or condition resulting in death): e. Cerebrovascular accident — 6 hrs
Dua to (or as a consaquanca of):
Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Diseasa or injury thet initiated avants rasulting in daath) Last:
b. Due to (or as a consaquance of):
c. Dua to (or es e consaquanca of):
d.

Part II. **Othar significant conditions** contributing to daath but not rasulting in tha underlying ceusa givan in Part I.

23b. Did tobacco uae contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an eutopsy parformad? 1☐ Yas 2☒ No
24b. Wara autopsy findings available prior to complation of causa of daath? 1☐ Yas 2☐ No

25. Was casa refarrad to madical examiner? 1☐ Yas 2☒ No

26. Placa of Daath *(Chack only ona)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Homa 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be datarmined

28a. Data of Injury *(Month, Day Year)*
28b. Tima of Injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurred
28a. Place of Injury - At homa, farm, streat, factory, office building, atc. *(Spacify)*
28f. Location *(Straat and Number or Rural Routa Number, City or Town, Stata)*

29a. Cartifiar *(Check only one)*: 1☒ **Certifying Physician:** To tha best of my knowledge, deeth occurrad at tha tima, date end plece, and dua to tha causa(s) and manner es stated. 2☐ **Medical Examiner:** On tha basis of examination and/or investigation, in my opinion, daath occurrad at the time, date and place, and dua to tha cause(s) and mannar stated.

29b. Signatura and title of certifiar: John C. Seymour MD
29c. Licansa number: D-13824
29d. Data signad *(Month, Day, Year)*: 11-17-98

30. Nama and Addrass of person who completed cause of deeth (Item 23a) (Type, Print): John C. Seymour 122 Speer Road, Chestertown, MD 21620

State Registrar

31. Data filad *(Month, Day, Year)*: NOV 17 1998
32. Registrer's Signature: [illegible] G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

3

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37067

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Dete of Deeth Month Day Year	3. Time of Death
John William Sparks Sr.	November 21, 1998	0537 A

4a Facility Neme (If not institution, give street and number)	4b. City, Town, or Location of Deeth	4c. County of Deeth
144 Dogwood Road	Elkton	Cecil

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	If Under 1 Year Days	If Under 24 Hrs. Hours	If Under 24 Hrs. Min.	8. Date of Birth (Month, Dey, Year)	9. Birthplace (State or Foreign Country)
229-24-7972	1☒ M 2☐ F	77 Yrs.					October 15, 1921	Virginia

Usuel Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Cecil	Elkton	1☐ Yes 2☒ No

10e. Street end Number	10f. Zip Code	10g. Citizen of What Country?
144 Dogwood Road	21921	United States

11. Maritel Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☒ Yes 2☐ No If Yes, Give Year or Dates: WWII 1945	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grede completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondary (0-12)	College (1-4or 5+)		
3		Press Operator	Consumer Packaging

17. Father's Neme (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
John Sparks	Minerva Morris

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code)
Wanda Faye Sparks/ Wife	144 Dogwood Road, Elkton, Maryland 21921

20a. Method of Disposition	20b. Placa of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Gilpin Manor Memorial Park	November 25, 1998	Elkton, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Donald S. Hicks	Hicks Home for Funerals, P.A. 103 West Stockton Street, Elkton, Maryland 21921

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Ceuse (Final disease or condition resulting in death)	a. COPD	>10yrs
Due to (or as e consequence of):		
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last	b. Lung CA	>3yrs
Due to (or as e consequence of):		
	c.	
Due to (or as e consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Piece of Deeth (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☒ Residenca 6☐ Other (Specify)

27. Menner of Deeth	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street end Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medicat Examiner:** On the besis of examination and/or investigation, in my opinion, death occurred et the time, date and placa, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)
▶ José Ma	D44716	November 23, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
José Ma M.D. W. High st Elkton MD 21921.

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 23 1998	Bruce P. Spahr

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): John Henry Strite				2. DATE OF DEATH (Month, Day, Year): 11 - 11 - 98	3. TIME OF DEATH: 12:35 A.M.
4. SOCIAL SECURITY NUMBER: 220-18-1931	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 96 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Oct. 24, 1902	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 900 Oak Hill Avenue			9b. CITY, TOWN OR LOCATION OF DEATH: Hagerstown		9c. COUNTY OF DEATH: Washington

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Washington	10c. CITY, TOWN OR LOCATION: Hagerstown	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 900 Oak Hill Avenue		10f. ZIP CODE: 21742	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: WWII	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 6	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): School Teacher	16b. KIND OF BUSINESS/INDUSTRY: Education	
17. FATHER'S NAME (First, Middle, Last): Newton E. Strite		18. MOTHER'S NAME (First, Middle, Maiden Surname): Clara V. Lesher	
19a. INFORMANT'S NAME (Type/Print): John H. Strite, II/Son		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 900 Oak Hill Avenue, Hagerstown, Maryland 21742	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): St. Paul Cemetery-Nov. 14,	DATE: 1998	20c. LOCATION — City or Town, State: Clear Spring, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Douglas A Fiery		22. NAME AND ADDRESS OF FACILITY: Douglas A. Fiery Funeral Home, 1331 Eastern Blvd., N., Hagerstown, MD 21742	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	CONGESTIVE HEART FAILURE	DAYS
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	CORONARY ARTERY DISEASE	YEARS
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

LUNG CARCINOMA, RENAL INSUFFICIENCY, PAROXYSMAL ATRIAL FIBRILLATION

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [X] NO [ ] UNCERTAIN [ ]

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Pamela Fox Bradford	29c. LICENSE NUMBER: D38892	29d. DATE SIGNED (Month, Day, Year): ▶ 11/12/98

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): PAMELA FOX BRADFORD, 11110 MEDICAL CAMPUS RD SUITE 130, HAGERSTOWN, MD 21742

31. DATE FILED (Month, Day, Year): NOV 13 1998	32. REGISTRAR'S SIGNATURE: Penny L. Sparks

DHMH-16 Rev 1/89

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37069

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Kenneth William Snodderly, Sr.

2. Date of Death — Month: November Day: 10 Year: 1998

3. Time of Death: 3:30 pm

4a. Facility Name *(If not institution, give street and number)*: 203 West Side Avenue

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 220-28-3395

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 65 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 2, 1933

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 203 West Side Avenue

10f. Zip Code: 21740

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1956-1958

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10 — College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Driver

16b. Kind of Business/Industry: Trucking

17. Father's Name *(First, Middle, Last)*: Walter C. Snodderly

18. Mother's Name *(First, Middle, Maiden Surname)*: Nellie Rommel

19a. Informant's Name/Relationship *(Type, Print)*: Kenneth Snodderly/Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 14704 Greencastle Pike Hagerstown,Maryland 21740

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other piece)*: Smithsburg Crematory — Date: 11-14-98

20c. Location - City or Town, State: Smithsburg,Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Osborne Funeral Home 425 S. Conococheague St.Williamsport,Maryland21795

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Arterioslerotic Heart Disease — years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest
b. Coronary Occlusion

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings availeble prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and manner es stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D01062

29d. Date signed *(Month, Day, Year)*: November 13, 1998

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print): Edward W. Ditto,III, M.D. 217 W. Washington St. Hagerstown, MD 21740

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 13 1998

32. Registrar's Signature: [signature]

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Clair Edward SIMMONS

2. Date of Death Month Day Year: November 7, 1998

3. Time of Death: 8:00 pm

4a. Facility Name *(If not institution, give street and number)*: 15624 National Pike

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 178-24-8884

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 67 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: March 26, 1931

9. Birthplace *(State or Foreign Country)*: Pennsylvania

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 15624 National Pike

10f. Zip Code: 21740

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1951-1953

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 0-10; College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: owner

16b. Kind of Business/Industry: electronics store

17. Father's Name *(First, Middle, Last)*: Clarence Simmons

18. Mother's Name *(First, Middle, Maiden Surname)*: Annie Hughes

19a. Informant's Name/Relationship *(Type, Print)*: Mrs. Dora A. Simmons / wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 15624 National Pike, Hagerstown, Maryland 21740

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Bermudian Church Cemetery

Date: Nov. 11, 1998

20c. Location - City or Town, State: East Berlin, Pennsylvania

21. Signature of Funeral Service Licensee: Scott Minnich

22. Name and Address of Facility: Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Lung Cancer — 2 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

28. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☑ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Michael J. McCormack MD

29c. License number: 041667

29d. Date signed *(Month, Day, Year)*: 11-9-98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michael J. McCormack 11110 Medical Campus Rd. Suite 130 Hagerstown MD 21742

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 10 1998

32. Registrar's Signature: Denise G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the **Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
To the **Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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RKD

98-6417-043

JERRY SMITH

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEMS: #23 PART I, 27, PER MEO G766 12-4-98 WR

Certificate of Death

Reg. No. 98-37071

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month / Dey / Year	3. Time of Death
Jerry Wayne Smith, Sr.		NOVEMBER 4, 1998	2:00A.M.
4a Facility Name (If not institution, give street end number)	**4b. City, Town, or Location of Death**	**4c. County of Death**	
WASHINGTON COUNTY HOSPITAL	HAGERSTOWN	WASHINGTON	

Funeral Director

5. Social Security Number	6. Sex	7. Age (in yrs. last birthdey)	If Under 1 Yeer: Months / Deys	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Dey, Year)	9. Birthplace (Stete or Foreign Country)
220-52-1510	1[X] M 2[ ] F	48 Yrs.			June 24 1950	Maryland

Usual Residence of Decedent

10a. Stete	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Washington	Maugansville	1[ ] Yes 2[X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of Whet Country?
13834 Village Mill Drive	21767	U.S.A.

11. Mariteł Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indien, Black, White, etc.
1[ ] Never Merried 2[X] Married 3[ ] Widowed 4[ ] Divorced	1[X] Yes 2[ ] No If Yes, Give Year or Detes: 1968-69	1[ ] Yes 2[X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grede completed)		16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondery (0-12)	College (1-4or 5+)		
10	0	Painter	Painting

17. Father's Neme (First, Middle, Last)	18. Mother's Neme (First, Middle, Maiden Sumeme)
Donald Jack Smith	Betty Joyce Smith

19e. Informent's Neme/Reletionship (Type, Print)	19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code)
Nancy J. Smith - Wife	13834 Village Mill Dr. Maugansville, Md. 21767

20a. Method of Disposition	20b. Piece of Disposition (Neme of cemetery, cremetory or other piece)	Dete	20c. Location - City or Town, State
1[ ] Burial 2[X] Cremation 3[ ] Removel from Stete 4[ ] Donetion 5[ ] Other (Specify)	Hagerstown Crematory	11/6/98	Hagerstown, Maryland

21. Signeture of Funeral Service Licensee	22. Name and Address of Facility
▶ Fred L Wetzel	Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heert failure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Death

Immediate Ceuse (Finel disease or condition resulting in death) e. HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASULAR DISEASE

Due to (or es e consequence of):

Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Cause (Disease or Injury thet initieted events resulting in deeth) Last

b. Due to (or es e consequence of):

c. Due to (or es e consequence of):

d.

Pert II. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contributa to tha cause of death? 1[ ] Yes 2[ ] No 3[ ] Probably 4[X] Unknown

24a. Wes en eutopsy performed?	24b. Were eutopsy findings aveilable prior to completion of cause of deeth?
1[X] Yes 2[ ] No	1[X] Yes 2[ ] No

25. Wes case referred to medical exeminer?	26. Piece of Deeth (Check only one)	
XX Yes 2[ ] No	Hospital: 1[ ] Inpetient 2[X] ER/Outpetient 3[ ] DOA	Other: 4[ ] Nursing Home 5[ ] Residence 6[ ] Other (Specify)

27. Manner of Deeth	28a. Dete of Injury (Month, Dey Yeer)	28b. Time of Injury M	28c. Injury et Work?	28d. Describe how injury occurred
1[X] Neturel 2[ ] Accident 3[ ] Suicide 4[ ] Homicide 5[ ] Pending investigation 6[ ] Could not be determined			1[ ] Yes 2[ ] No	
	28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one)

1[ ] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

2[X] **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, dete end place, and due to the ceuse(s) and manner stated.

29b. Signeture end title of certifier	29c. License number	29d. Dete signed (Month, Dey, Yeer)
▶ Theodore M. King MD	O.C.M.E.	NOVEMBER 5, 1998

30. Neme end eddress of person who completed ceuse of death (Item 23e) (Type, Print)

THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Dey, Yeer)	32. Registrar's Signature
NOV 10 1998	▶ G. Sparks

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37072

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Dey / Yeer	3. Time of Death
JOHN	CONRAD	TWENTY	NOVEMBER 11, 1998	4:35 AM

4e. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Frederick Memorial Hospital	Frederick	Frederick

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Deys	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Dey, Yeer)	9. Birthplace (State or Foreign Country)
220-16-1593	1☒ M 2☐ F	85 Yrs.			Sept. 8, 1913	Maryland

Usual Residence of Decedent

10e. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Frederick	Frederick	1☒ Yes 2☐ No

10e. Street end Number	10f. Zip Code	10g. Citizen of Whet Country?
812 Shawnee Drive	21701	U. S. A.

11. Marital Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.)	14. Race - American Indien, Bleck, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Yeer or Detes:	1☐ Yes 2☒ No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11		Clerk	Frederick Trading Co.

17. Fether's Neme (First, Middle, Last)	18. Mother's Neme (First, Middle, Maiden Sumeme)
John C. Twenty	Della Reeder

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)
Virginia Twenty - Wife	812 Shawnee Drive, Frederick, Maryland 21701

20a. Method of Disposition	20b. Placa of Disposition (Neme of cemetery, cremetory or other piece)	Dete	20c. Location - City or Town, Stete
1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)	Mt. Olivet Cemetery	11/13/98	Frederick, Maryland

21. Signature of Funeral Service Licensee	22. Neme end Address of Feciility
▶ Sharon Camille Cline	Stauffer Funeral Homes, P. A. 1621 Opossumtown Pike, Frederick, Md. 21702

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions thet caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert failure. List only one ceuse on eech line.

		Approximate Interval Between Onset end Death
Immediate Cause (Final disease or condition resulting in death)	e. Coronary artery disease	5 years.
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last	b. Due to (or es e consequenca of):	
	c. Due to (or es e consequence of):	
	d. Due to (or es e consequence of):	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Wes en eutopsy performed?	24b. Were eutopsy findings eveilable prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical exeminer?	26. Plece of Deeth (Check only one)	
1☐ Yes 2☒ No	Hospitel: 1☐ Inpetient 2☒ ER/Outpetient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Dey Yeer)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.
2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end piece, and due to the cause(s) and manner stated.

29b. Signature end title of certifier	29c. License number	29d. Date signed (Month, Dey, Yeer)
▶ K. Barakat	D21648	11/12/98

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
KUSAY BARAKAT 310 W. 9th Street Frederick MD 21701

State Registrar

31. Date filed (Month, Dey, Yeer)	32. Registrar's Signature
NOV 13 1998	▶ penne B. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37073

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: SUSAN E. TURANO
2. Dete of Deeth — Month: Nov. Dey: 20, Yeer: 1998
3. Time of Death: 1800

4e Feciity Neme *(If not institution, give street end number)*: ALLEGANY COUNTY NURSING HOME
4b. City, Town, or Location of Deeth: CUMBERLAND
4c. County of Deeth: ALLEGANY

Funeral Director

5. Social Security Number: 218-80-1264
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. lest birthday)*: 82 Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Dey, Yeer)*: Nov 19, 1916
9. Birthplece *(State or Foreign Country)*: WV

Usuel Residence of Decedent

10a. State: MD
10b. County: Allegany
10c. City, Town or Location: Cumberland
10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 108 S. Johnson Street
10f. Zip Code: 21502
10g. Citizen of Whet Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Educetion *(Specify only highest grede completed)*: Elementery/Secondary (0-12): 12 — College (1-4or 5+):
16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Fether's Neme *(First, Middle, Last)*: Thomas Sowers
18. Mother's Name *(First, Middle, Maiden Surneme)*: Adda (Largent)

19a. Informant's Name/Relationship *(Type, Print)*: John A. Turano--husband
19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 108 S. Johnson Street; Cumberland, MD 21502

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other piece)*: Hillcrest Memorial Park
Dete: 11/23
20c. Location - City or Town, Stete: Cumberland, MD

21. Signeture of Funeral Service Licensee: ▶ Nicholas J. Scarpelli
22. Neme end Address of Facility: Scarpelli Funeral Home, P.A. Cumberland, MD 21502

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications that caused the deth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset end Deeth
Immediate Ceuse (Finel diseese or condition resulting in death)	e. Anemia + renal failure	2 weeks
	Due to (or es e consequence of):	
Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last	b. Severe dehydration	1 month
	Due to (or es e consequence of):	
	c. Recent C.V.A c dysphagia	2 months
	Due to (or es e consequence of):	
	d.	

Part II. **Other significent conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.: Hypertension, type II Diabetis Mellitus

23b. Did tobecco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probebly 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Was cese referred to medical examiner? 1☐ Yes 2☒ No
26. Plece of Death *(Check only one)*: Hospital: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Dey Yeer)*
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rurel Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physicien:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and manner es steted. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) end menner steted.

29b. Signeture end title of certifier: ▶ V. A. Ranjithan
29c. License number: D19750.
29d. Date signed *(Month, Dey, Yeer)*: Nov, 21, 1998.

30. Neme end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print): V.A. Ranjithan, M.D.; 517 Oldtown Road; Cumberland, MD 21502

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: NOV 23 1998
32. Registrar's Signeture: ▶ D. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Meryiend Department of Health end Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37074

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Marshall Stuart Twigg

2. Dete of Death — Month: NOVEMBER Dey: 22, Year: 1998

3. Time of Death: 1555p.m.

4a Facility Neme *(If not institution, give street and number)*: Sacred Heart Hospital

4b. City, Town, or Location of Death: Cumberland

4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 220-10-0729

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 74 Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Dey, Year)*: Apr 23, 1924

9. Birthplece *(State or Foreign Country)*: Maryland

Usuel Residence of Decedent

10a. Stete: Maryland

10b. County: Allegany

10c. City, Town or Location: Cumberland

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 235 Paca St., Apt. # 502

10f. Zip Code: 21502

10g. Citizen of Whet Country?: USA

11. Meritel Status: 1☒ Never Married 2☐ Merried 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Yeer or Detes: 1941-46

13. Was Decedent of Hispanic Origin? (Specify Yes or No- tt Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indien, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 12 — College (1-4or 5+):

16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Stock Clerk

16b. Kind of Business/Industry: Department Store

17. Fether's Neme *(First, Middle, Last)*: Marshall C. Twigg

18. Mother's Neme *(First, Middle, Maiden Surneme)*: Esther Louise (Hinman)

19e. Intorment's Neme/Reletionship *(Type, Print)*: William G. Kight

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 309-311 Decatur St., Cumberland, MD 21502

20e. Method ot Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Plece ot Disposition *(Neme of cemetery, cremetory or other piece)*: St. Lukes Lutheran Cem. — Dete: 11/25/98 — 20c. Location - City or Town, Stete: Cumberland, MD

21. Signeture of Funerel Service Licensee: William G. Kight

22. Neme end Address ot Fecility: Kight Funeral Home 309-311 Decatur St., Cumberland, MD 21502

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications that caused the deeth. Do not enter the mode ot dying, such es cardiac or respiratory errest, shock, or heert tellure. List *only one* ceuse on each line.

Approximate Intervel Between Onset end Death

Immediate Ceuse (Final disease or condition resulting in deeth)

a. Carcinoma lung — Due to (or es a consequence ot): — 2 years

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in deeth) Lest

b. — Due to (or es e consequence ot):

c. — Due to (or es e consequenca of):

d.

Part II. **Other signiftcant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

Emphysema

Arteriosclerosis

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveilable prior to completion ot cause ot deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☑ No

26. Place of Deeth *(Check only one)*: Hospital: 1☒ Inpetient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner ot Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete ot Injury *(Month, Dey Year)* — 28b. Time of Injury — M — 28c. Injury at Work? 1☐ Yes 2☐ No — 28d. Describe how injury occurred

28e. Plece ot Injury - At home, farm, street, factory, office building, etc. *(Specify)* — 28f. Location *(Street and Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best ot my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end manner steted.

29b. Signeture end title of certifier: George Brega MD

29c. License number: D12532

29d. Date signed *(Month, Dey, Year)*: Nov/23/98

30. Neme and eddress ot person who completed cause of deeth (Item 23a) (Type, Print): George Brega, M.D. 912 Seton Drive Cumberland MD 21502.

State Registrar

31. Dete filed *(Month, Dey, Year)*: NOV 25 1998

32. Registrer's Signeture: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

98-6814-001
wayne craig taylor
wlc

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37075

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Wayne Craig Taylor

2. Date of Death Month Dey Yeer: Novmeber 20, 1998

3. Time of Death: 305p

4e Facility Name (If not institution, give street and number): MEMORIAL HOSPITAL

4b. City, Town, or Location of Deeth: CUMBERLAND

4c. County of Deeth: ALLEGANY

Funeral Director

5. Social Security Numbar: 205-44-5580

6. Sax: 1☒ M 2☐ F

7. Aga (In yrs. lest birthday): 47 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Yeer): Aug. 31, 1951

9. Birthplaca (State or Foraign Country): MARYLAND

Usual Residenca of Decadent

10a. Stete: Maryland

10b. County: Allegany

10c. City, Town or Location: Flintstone

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 20301 North Service Drive NE

10f. Zip Code: 21530

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorcad

12. Was Decedent Ever in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yas, Giva Yeer or Detes:

13. Was Decedant of Hispenic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, Whita, etc. Specify: White

15. Decadent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): Self Employeed Truck Driver

16b. Kind of Business/Industry: Trucking

17. Fether's Name (First, Middle, Last): Don James Taylor

18. Mother's Name (First, Middle, Maiden Surneme): Dorothy Strickland

19a. Informent's Name/Relationship (Type, Print): Judy Taylor - Wife

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 20301 N. Service Dr. NE, Flintstone, MD 21530

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other pleca): Fairview Christian Cemetery

Date: Nov 24, 1998

20c. Location - City or Town, Stete: Artemas, PA

21. Signature of Funeral Servica Licansee: Douglas D Hafer

22. Nama and Addrass of Facility: Hafer Chapel of the Hills Mortuary, 1302 National Hwy, LaVale, MD 21502

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel Hygiene.

Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the daath. Do not enter tha moda of dying, such es cardiec or respiretory arrest, shock, or heert failura. List only one cause on eech line.

Approximete Intervel Between Onset end Death

Immediate Cause (Final diseese or condition resulting in death): e. HEAD AND NECK injuries

Due to (or es e consequenca of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest

b. Due to (or es e consequence of):

c. Due to (or es e consequenca of):

d.

Part II. **Other significant conditione** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was en eutopsy performed? 1☒ Yes 2☐ No

24b. Were eutopsy findings eveilable prior to completion of cause of death? 1☒ Yes 2☐ No

25. Wes case referred to medical examiner? 1☒ Yes 2☐ No

26. Piece of Death (Check only one) Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Naturel 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Yeer): 11-20-98

28b. Time of Injury: Eand 1400 M

28c. Injury et Work? 1☐ Yes 2☒ No

28d. Describe how injury occurred: AND EJECTION DRIVER OF TRUCK, OVERTURNED

28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify): ROADWAY

28f. Location (Street end Number or Rural Route Number, City or Town, State): RT 326 BEDFORD CO. PENNSYLVA- N/A

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end pleca, end due to the ceuse(s) and manner es steted. 2☒ **Medical Examiner:** On the besis of examination end/or investigation, In my opinion, death occurred et the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: Wayne Craig Taylor MD

29c. License number: O.C.M.E.

29d. Data signed (Month, Dey, Yeer): November 21, 1998

30. Neme and eddress of person who completed cause of death (Item 23a) (Type, Print): MD Raymond A. Konen 111 Penn Street, Baltimore, Maryland 21201

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funerel director, page 2 should be detached for use as the burieł-transit

20

JKS

State Registrar

31. Dete filed (Month, Day, Year): NOV 23 1998

32. Registrer's Signeture: Jeanne B. Sparks

DHMH 16 Rev 6/95

98-6545-023
crn
Gerald Eugene Twigg, Sr.
ITEMS: #23 PART I, 28A-F PER MEO G766 12-4-98

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

WR

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Gerald Eugene TWIGG, Sr.
2. Date of Death (Month, Day, Year): November 10, 1998
3. Time of Death: 12:30 P.M.
4a. Facility Name (If not institution, give street and number): Garrett Memorial Hospital
4b. City, Town, or Location of Death: Oakland
4c. County of Death: Garrett

Funeral Director

5. Social Security Number: 214-66-5952
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 44 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 6, 1954
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Garrett
10c. City, Town or Location: Oakland
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 400 Yough West, Apt. 16
10f. Zip Code: 21550
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates: X
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Coal Miner
16b. Kind of Business/Industry: Coal Mining

17. Father's Name (First, Middle, Last): Robert Leroy Twigg, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Delores Pauline Juratovac

19a. Informant's Name/Relationship (Type, Print): Robert L. Twigg, Sr./Father
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 400 Yough West, Apt. 16, Oakland, MD 21550

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Omega Crematory
Date: 11/12/98
20c. Location - City or Town, State: Morgantown, WV

21. Signature of Funeral Service Licensee: ▶ Bradley A. Sparks
22. Name and Address of Facility: Stewart Funeral Home, 32 S. Second St., Oakland, MD 21550

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): e. NARCOTIC INTOXICATION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an autopsy performed? 1 [✓] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [X] Could not be determined

28a. Date of Injury (Month, Day, Year): Found 11-10-98
28b. Time of Injury: Found: 8:40 A M
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: UNKNOWN
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): FOUND: APARTMENT
28f. Location (Street and Number or Rural Route Number, City or Town, State): 610 PENSINGER BLVD. MOUNTAIN LAKE PARK, GARRETT CO. MD.

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Marjorie Ann Snell M.D.
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): November 11, 1998

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): MARJORIE A. SNELL M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): NOV 20 1998
32. Registrar's Signature: Geneva G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4

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amend item 5,11 per informant G790 12/27/00 yf

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 07077

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Robert Leroy TWIGG, Sr.

2. Date of Death: Month November Dey 16, Year 1998

3. Time of Death: 10:30 AM

4a. Facility Name (If not institution, give street and number): 400 Yough West, Apt. 16

4b. City, Town, or Location of Death: Oakland

4c. County of Death: Garrett

Funeral Director

5. Social Security Number: ~~212-26-9592~~ 218-26-9592

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 67 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 9-5-1931

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Garrett

10c. City, Town or Location: Oakland

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street end Number: 400 Yough West, Apt.16

10f. Zip Code: 21550

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married ~~3 [X] Widowed~~ 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Yeer or Detes: 1950

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 8th | College (1-4or 5+):

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Barber

16b. Kind of Business/Industry: Barber Shop

17. Father's Neme (First, Middle, Last): James Ross Twigg

18. Mother's Name (First, Middle, Maiden Surname): Lula Victoria Spencer

19a. Informant's Neme/Relationship (Type, Print): Gary G. Twigg/ Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11620 Partridge Run Lane, Potomac MD 20854

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremetion 3 [ ] Removel from State 4 [ ] Donetion 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Omega Crematory

Date: 11/17/98

20c. Location - City or Town, Stete: Morgantown, WV

21. Signeture of Funerel Service Licensee: Bradley A. Stewart

22. Name and Address of Facility: Stewart Funeral Home, 32 S. Second St., Oakland, MD 21550

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart tailure. List only one ceuse on eech tine.

Approximate Intervel Between Onset end Death

Immediate Cause (Final disease or condition resulting in death): e. Adenocarcinoma-metastatic — 6 months

Due to (or as e consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in deeth) Lest

b. Due to (or es e consequence of):

c. Due to (or es e consequence of):

d.

Pert II. **Other significant conditione** contributing to death but not resulting in the underlying cause given in Pert I.

diabetes type II, breast cancer, hypertension, morbid obesity

23b. Did tobecco uee contribute to the cauee of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Plece of Deeth (Check only one): Hospital: 1 [ ] Inpetient 2 [ ] ER/Outpetient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Deeth: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Pleca of Injury - At home, ferm, street, fectory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. 2 [ ] **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end plece, end due to the cause(s) end menner stated.

29b. Signature and title of certifier: Margaret A Kaiser MD

29c. License number: D26650

29d. Date signed (Month, Day, Year): 11/17/98

30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print): Margaret A. Kaiser, MD 13079 Garrett Highway, Oakland, MD 21550

6

State Registrar

31. Dete filed (Month, Day, Year): NOV 20 1998

32. Registrer's Signature: Jenna G. Sparks

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37078

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): RALPH THOMAS
2. Date of Death: Month 11 Day 17 Year 98
3. Time of Death: 1301
4a. Facility Name (If not institution, give street and number): 270 Fearer Road
4b. City, Town, or Location of Death: Friendsville
4c. County of Death: Garrett

Funeral Director

5. Social Security Number: 215-18-8554
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 91 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 2, 1907
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Garrett
10c. City, Town or Location: Friendsville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 270 Fearer Road
10f. Zip Code: 21531
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 8 | College (1-4or 5+):
16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): Air Conditiong Services
16b. Kind of Business/Industry: Air Conditioning & Refrigeration Install.

17. Father's Name (First, Middle, Last): Ephram Thomas
18. Mother's Name (First, Middle, Maiden Surname): Minnie Dietrick

19a. Informant's Name/Relationship (Type, Print): Jesse Thomas/Son
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 557 Hilltop Circle, Greencastle, PA 17225

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Asher Glade Cem, Date: Nov. 21, 1998
20c. Location - City or Town, State: Friendsville, MD 21531

21. Signature of Funeral Service Licensee: Ruth K. Newman
22. Name and Address of Facility: Newman Funeral Homes, P.A. 179 Miller St., PO Box 275, Grantsville, MD 21536

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death: minute

Immediate Cause (Final disease or condition resulting in death): e. ARTERIOSCEROTIC CORONARY/VASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Dete of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner es steted. 2☒ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature end title of certifier: Paul Dennis Miller Jr.
29c. License number: H26154
29d. Date signed (Month, Dey, Year): 11/18/98

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print): 69 Wolfe Acres Drive Oakland, MD 21550

10+IVA

State Registrar

31. Date filed (Month, Dey, Year): NOV 19 1998
32. Registrar's Signature: Jenna B. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37079

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Dey / Yeer	3. Time of Death
ROGER	S.	TAIT	NOVEMBER 17, 1998	8:00 AM

4a Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
LAURELWOOD CARE CENTER	ELKTON	CECIL

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Deys	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
061-18-8376	1☒M 2☐F	75 Yrs.			7/25/23	BRONX, NY

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
DE	NEW CASTLE	WILMINGTON	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of Whet Country?
2713 BARDELL DRIVE	19808	U.S.A.

11. Marital Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Bleck, White, etc.
1☐Never Married 2☒Mamed 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Detes:	1☐Yes 2☒No Specify:	Specify: WHITE

15. Decedent's Eduestion (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	2	CARPENTER	CONSTRUCTION

17. Fether's Name (First, Middle, Last)	18. Mother's Neme (First, Middle, Maiden Surneme)
ROBERT TAIT	VIOLA STRADINGER

19a. Informant's Name/Relationship (Type, Print)	19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code)
GRACE TAIT	2713 BARDELL DRIVE, WILMINGTON, DE 19808

20a. Method of Disposition	20b. Piece of Disposition (Name of cemetery, crematory or other piece)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremetion 3☐Removal from State 4☐Donation 5☐Other (Specify)	R.A.FERRIS & CO., INC. WEST CHESTER, PA	NOV 18 1998	WEST CHESTER, PA

21. Signature of Funeral Service Licensee	22. Name end Address of Facility
CHARLES F. MEALEY, JR.	MEALEY FUNERAL HOMES PO BOX 2866, WILMINGTON, DE 19805

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart tailure. List only one cause on eech line.

		Approximate Interval Between Onset end Death
Immediate Cause (Finel disease or condition resulting in death)	e. Cerebrovascular disease	>1 year
	Due to (or as e consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last	b.	
	Due to (or es e consequence of):	
	c.	
	Due to (or es e consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were eutopsy findings eveilable prior to completion of cause of deeth?
1☐Yes 2☒No	1☐Yes 2☒No

25. Was case referred to medical examiner?	26. Place of Deeth (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Naturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

29a. Certifier (Check only one) 1☒**Certifying Physician**: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner es steted. 2☐**Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	D28339	November 17, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type or Print) LINDA FAIRLIGHT 101 E Wheel Road Bel Air MD 21015

State Registrar

31. Date filed (Month, Day, Year)	32. Registrer's Signeture
NOV 18 1998	Glenda G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 57080

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Samuel Gilmore Umstot

2. Date of Death (Month, Day, Year): NOVEMBER 19 1998

3. Time of Death: 12:15 PM

4a Facility Name *(If not institution, give street and number)*: MEMORIAL HOSPITAL MEDICAL CENTER

4b. City, Town, or Location of Death: CUMBERLAND

4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 234-01-8486

6. Sex: X M 2 F

7. Age *(In yrs. last birthday)*: 96 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Sep 28, 1902

9. Birthplace *(State or Foreign Country)*: WV

Usual Residence of Decedent

10a. State: MD

10b. County: Allegany

10c. City, Town or Location: Cumberland

10d. Inside City Limits: X 1 Yes 2 No

10e. Street and Number: 607 Elm Street

10f. Zip Code: 21502

10g. Citizen of Whet Country?: USA

11. Marital Status: 1 Never Married 2 Married X Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 Yes X No If Yes, Give Year or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes X No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Retired

16b. Kind of Business/Industry: Ballistics

17. Father's Name *(First, Middle, Last)*: Ulysess G. Umstot

18. Mother's Name *(First, Middle, Maiden Surname)*: Susan Delara (Skelly)

19a. Informant's Name/Relationship *(Type, Print)*: Sharon Knotts-granddaughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: Route 2 Box 239-0; Ridgeley, WV 26753

20a. Method of Disposition: X 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Fort Ashby Cemetery

Date: 11/21

20c. Location - City or Town, State: Fort Ashby, WV

21. Signature of Funeral Service Licensee: ▶ James J Scarpelli

22. Name and Address of Facility: Scarpelli Funeral Home, P.A. Cumberland, MD 21502

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute & chronic congestive heart failure — 2 weeks

Due to (or as a consequence of):

b. ashd — 10 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Aspiration pneumonia

23b. Did tobecco usa contributa to the cause of death? 1 Yes 2 X No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 X No

24b. Were eutopsy findings available prior to completion of cause of death? 1 Yes 2 X No

25. Was case referred to medical examiner? 1 Yes 2 X No

26. Place of Death *(Check only one)*: Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA — Other: 4 Nursing Home 5 Residence 6 Other *(Specify)*

27. Manner of Death: 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end menner as stated. 2 **Medical Examinar:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signature and title of certifier: ▶ [signature]

29c. License number: D 14865

29d. Date signed *(Month, Day, Yeer)*: NOV. 19, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ROBUSTIANO BARRERA M.D., MEMORIAL HOSPITAL MEDICAL BLDG., CUMBERLAND, MD 21502

State Registrar

31. Dete filed *(Month, Day, Year)*: NOV 23 1998

32. Registrar's Signature: ▶ [signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

SAMUEL UMSTOT 234-01-8486
Division of Vital Records, P.O. Box 68760,

5
YLS

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98-3700

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Frances Evelyn Vaughn

2. Data of Death — Month: November Day: 8 Yaar: 1998

3. Tima of Daath: 3:40 Am

4a. Facility Nama *(If not institution, giva street and number)*: Washington County Hospital

4b. City, Town, or Location of Death: Hagerstown

4c. County of Daath: Washington

Funeral Director

5. Social Sacurity Number: 176-05-2679A

6. Sex: 1☐ M 2☒ F

7. Aga *(In yrs. last birthday)*: 88 Yrs. — If Under 1 Yaar: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Yaar)*: Aug. 16, 1910

9. Birthplaca *(Stata or Foraign Country)*: Maryland

Usual Rasidance ot Decadant

10a. Stata: Maryland

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Insida City Limits: 1☒ Yas 2☐ No

10e. Street and Numbar: 734 W. Franklin Street

10f. Zip Coda: 21740

10g. Citizen of Whet Country?: USA

11. Marital Status: 1☐ Navar Marriad 2☐ Marriad 3☒ Widowed 4☐ Divorcad

12. Was Dacadant Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No — If Yas, Giva Yaar or Datas:

13. Wes Dacadant ot Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 1☐ Yas 2☒ No *Spacify:*

14. Race - American Indian, Black, Whita, atc. *Spacify:* White

15. Decadent's Educetion *(Specify only highast grade complatad)* — Elementary/Secondary (0-12): 12 — College (1-4or 5+):

16a. Dacadant's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa ratired)*: assembler

16b. Kind ot Businass/Industry: Fairchild Aircraft

17. Fathar's Nama *(First, Middla, Last)*: Hubert A. Stottlemyer

18. Mothar's Nama *(First, Middla, Maidan Surnama)*: Blanche E. Fisher

19a. Informant's Name/Ralationship *(Typa, Print)*: Larry A. Vaughn Son

19b. Mailing Address *(Straat and Numbar or Rural Routa Numbar, City or Town, Stata, Zip Coda)*: 734 W. Franklin Street Hagerstown, Maryland 21740

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Placa ot Disposition *(Nama of camatary, cramatory or othar placa)*: Rest Haven Cemetery — Data: 11/12/98

20c. Location - City or Town, Stata: Hagerstown, Maryland

21. Signatura of Funaral Sarvica Licansaa: Gerald N. Minnich

22. Nama and Addrass of Facility: Gerald N. Minnich Funeral Home — 305 N. Potomac Street Hagerstown, Maryland 21740

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only ona cause on each line.

		Approximate Intarval Batwaan Onsat and Daath
Immediata Causa (Final disaasa or condition rasulting in daath) a.	Morphine	2-3 days
Due to (or as a consequance ot): b.	Pneumonia	2-3 wks
Sequantially list conditions, if any, laading to immadiata causa. Enter Undarlying Cause (Disaasa or injury that initiatad avants rasulting in daath) Last — Due to (or as a consequance of): c.	Cerebrovascular Accident	2-3 months
d.		

Part II. **Othar algnificant conditions** contributing to death but not rasulting in tha undarlying cause given in Part I.: Diabetes Mellitus Congestive Heart Failure End Stage Renal Disease

23b. **Did tobacco usa contribute to the causa of death?** 1☐ Yaa 2☐ No 3☐ Probably 4☐ UnKnown

24a. Was an autopsy parformed? 1☐ Yas 2☒ No

24b. Wara autopsy findings available prior to complation of cause of death? 1☐ Yes 2☐ No

25. Was casa ratarrad to medical examiner? 1☐ Yas 2☒ No

26. Placa ot Death *(Chack only ona)* — Hospital: 1☒ Inpatiant 2☐ ER/Outpatiant 3☐ DOA — Othar: 4☐ Nursing Homa 5☐ Rasidance 6☐ Othar *(Specify)*

27. Manner ot Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be datarminad

28a. Placa ot Injury - At home, tarm, straat, factory, office building, atc. *(Spacify)*

28b. Tima ot Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurrad

28t. Location *(Straat and Numbar or Rural Routa Numbar, City or Town, Stata)*

29a. Certifier *(Check only one)* 1☒ **Certifying Phyaician:** To tha best ot my knowladga, death occurrad at tha tima, data and placa, and dua to tha causa(s) and manner as statad. 2☐ **Madical Examinar:** On tha basis ot axamination and/or invastigation, in my opinion, death occurrad at tha tima, data and placa, and dua to tha causa(s) and manner stated.

29b. Signatura and title of certifiar: [illegible] MD

29c. Licansa number: D 18019

29d. Data signad *(Month, Day, Yaar)*: Nov 8, 1998

30. Nama and addrass ot parson who complatad causa ot daath (Itam 23a) (Typa, Print): Dr. Datta 334 Mill St. Hag. Md

State Registrar

31. Data filad *(Month, Day, Yaar)*: NOV 09 1998

32. Ragistrar's Signatura: Donald G. Sparks

DHMH 16 Rev 6/95

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Vaughn, Frances E

Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37082

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Dorothy Louise Watkins
2. Dete of Deeth — Month: November; Day: 21; Year: 1998
3. Time of Deeth: 9:15 PM
4a. Feciility Name *(If not institution, give street and number)*: Collingswood Nursing Center
4b. City, Town, or Location of Deeth: Rockville
4c. County of Deeth: Montgomery

Funeral Director

5. Social Security Number: 214-30-0104
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 85 Yrs. — If Under 1 Year: Months / Deys; If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Day, Year)*: May 3, 1913
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. Stete: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 3398 Gleneagles Drive
10f. Zip Code: 20906
10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Bieck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11; College (1-4or 5+):
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own home.

17. Fether's Neme *(First, Middle, Last)*: Ernest Edward Hawkins
18. Mother's Name *(First, Middle, Maiden Surname)*: Eva Louise Burdette

19a. Informent's Name/Relationship *(Type, Print)*: Linda W. Andrews - Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 14826 Carrolton Road, Rockville, Maryland 20853

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Piece of Disposition *(Name of cemetery, crematory or other place)*: Salem Cemetery
Date: 11/25/98
20c. Location - City or Town, Stete: Germantown, Maryland

21. Signature of Funeral Service Licensee: Olin L. Molesworth
22. Name end Address of Feciility: Olin L. Molesworth P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Deeth

Immediate Ceuse (Final disease or condition resulting in deeth)
a. Aspiration pneumonia — 6 days
Due to (or es e consequence of):
b. dementia
Due to (or es e consequence of):
Sequentially list conditions, if eny, leeding to Immediete cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Lest
c. slp CVA
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: poor dentition

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings aveilable prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Was cese referred to medical exeminer? 1☐ Yes 2☒ No

26. Piece of Deeth *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end menner es steted.
2☐ **Medical Examiner:** On the basis of examination end/or investigetion, In my opinion, deeth occurred at the time, date end place, end due to the ceuse(s) end menner stated.

29b. Signature end title of certifier: Physician
29c. License number: D0005352F
29d. Date signed *(Month, Day, Year)*: November 23, 1998

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print): DAphne Henkin, MD 2309 Shorefield Road Wheaton, MD 20902

State Registrar

31. Dete filed *(Month, Day, Year)*: NOV 23 1998
32. Registre's Signeture: Geneva B. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylend Department of Health end Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37083

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
BARBARA D. WELLS	NOVEMBER 8, 1998	11:20AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
THE JOHNS HOPKINS HOSPITAL	BALTIMORE CITY	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219-12-3634	1☐ M 2☒ F	73 Yrs.			June 9 1925	Wash. DC

Usual Residance of Decedant

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Montgomery	Dickerson	1☐ Yas 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
17900 Elmer School Road	20842	USA

11. Meritel Stetus	12. Wes Decedent Evar in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puerto Rican, atc.)	14. Race - American Indian, Black, Whita, atc.
1☐ Nevar Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yas 2☒ No If Yas, Giva Year or Dates:	1☐ Yes 2☒ No *Specify:*	*Specify:* white

15. Decedent's Education (Specify only highast grade completed)		16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondery (0-12)	College (1-4or 5+)		
	4	Teacher's Aide	Public schools

17. Fathar's Nema (First, Middla, Last)	18. Mother's Name (First, Middle, Maiden Sumama)
Telfair Bowie Dorsett	Helen Elizabeth Jeffery

19a. Informant's Name/Ralationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)
Clinton F Wells, Jr spouse	17900 Elmer School Rd. Dickerson, MD 20842

20a. Mathod of Disposition	20b. Place of Disposition (Nama of cematery, crematory or othar place)	Data	20c. Location - City or Town, State
1☐ Burial 2☒ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Specify)	Enders/Shirley F.H.	11/14	Berryville, VA

21. Signatura of Funaral Servica Licensee	22. Nama and Addrass of Facility
▶ [signature]	Hilton Funeral Home Barnesville, MD 20838

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Entar tha disaasa, or complications that caused tha deeth. Do not entar tha moda of dying, such as cardiac or respiretory errest, shock, or haart failura. List only one cause on each line.

		Approximete Intarval Between Onset and Death
Immediata Causa (Final disease or condition resulting in death)	a. anoxic brain injury	2weeks
	Dua to (or as a consequence of):	
Sequantially list conditions, if any, leading to immediate causa. Entar Underlying Cause (Disease or injury that initieted avants resulting in death) Last	b. pulseless electrical activity arrest	2weeks
	Dua to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not rasulting in the undarlying causa given in Part I.

coronary artery disease

cerebrovascular disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was casa rafarred to medical examinar? 1☐ Yas 2☒ No

26. Place of Deeth (Check only one): Hospital: 1☒ Inpatiant 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Homa 5☐ Rasidence 6☐ Othar (Specify)

27. Mennar of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Panding investigation 6☐ Could not be datarmined

28a. Data of Injury (Month, Day Yaar) | 28b. Tima of Injury | 28c. Injury at Work? 1☐ Yas 2☒ No | 28d. Describe how injury occurred

28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Cartifiar (Check only one): 1☒ **Certifying Physician:** To tha best of my knowledge, daath occurred at tha tima, date and place, and dua to tha causa(s) and mannar es steted. 2☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and mannar stated.

29b. Signatura and titla of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Christine D. Bussey MD	RES-000	NOVEMBER 8, 1998

30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print)

Christine Bussey, MD. 600 North Wolfe Street, Tower 110, Baltimore, Maryland 21287

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Deta filed (Month, Day, Year) NOV 13 1998

32. Registrar's Signatura ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37004

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mae Rose Williams
2. Date of Death (Month, Day, Year): November 5, 1998
3. Time of Death: 7:05 P.M.

4a. Facility Name (If not institution, give street and number): FREDERICK MEMORIAL HOSPITAL
4b. City, Town, or Location of Death: FREDERICK
4c. County of Death: FREDERICK

Funeral Director

5. Social Security Number: 217-28-6133
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JAN. 3, 1909
9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: MD.
10b. County: FREDERICK
10c. City, Town or Location: FREDERICK
10d. Inside City Limits: X 1☐ Yes 2☐ No
10e. Street and Number: 236 MADISON AVE.
10f. Zip Code: 21701
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - Americen Indian, Black, White, etc. Specify: BLACK

15. Decedent's Educetion (Specify only highest grade completed): Elementery/Secondery (0-12): 12 TH | College (1-4or 5+):
16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): HOUSEKEEPING
16b. Kind of Business/Industry: HOSPITAL

17. Father's Name (First, Middle, Last): CLAUDE A. DeLAUTER
18. Mother's Name (First, Middle, Maiden Surname): BERTHA AMBUSH

19a. Informant's Name/Relationship (Type, Print): CLAUDE DeLAUTER (BROTHER)
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 236 MADISON AVE. FREDERICK, MD. 21701

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): FAIRVIEW CEM. Dete: 11 NOV 1998
20c. Location - City or Town, State: FREDERICK

21. Signature of Funeral Service Licensee: ▶ Gary L. Rollins
22. Name and Address of Facility: GARY L. ROLLINS FUNERAL HOME 110 WEST SOUTH ST. FREDERICK, MD. 21701

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ASYSTOLE
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last:
b. PROBABLE ARTERIOSCLEROTIC CARDIO-VASC DISEASE
Due to (or as a consequence of):
c.
Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the ceuse of death?** 1☐ Yee 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☐ No
24b. Were autopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Was case referred to medicel examiner? 1☐ Yes 2☐ No
26. Plece of Death (Check only one): Hospital: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑ **Certifying Phyaician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end menner as stated. 2☐ **Medical Examiner:** On the besis of examination and/or Investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ George I. Smith Jr M.D. VPHA FREDERICK MEM HOSP
29c. License number: D 10587
29d. Date signed (Month, Day, Year): 11/9/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GEORGE I. SMITH JR M.D. VPHA — FREDERICK MEM HOSP. 400 W. 7TH ST., FREDERICK, MD. 21701

State Registrar

31. Date filed (Month, Day, Year): NOV 09 1998
32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37085

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Dey / Yeer	3. Time of Death
MARGARET		WATTS	NOVEMBER 16, 1998	10:15 AM

4e. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
FREDERICK MEMORIAL HOSPITAL	FREDERICK	FREDERICK

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Deys	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-34-0314	1☐M 2☒F	63 Yrs.			MAY 14, 1935	MD.

Usual Residence of Decedent

10e. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.	FREDERICK	FREDERICK	1☒Yes 2☐No

10e. Street end Number	10f. Zip Code	10g. Citizen of Whet Country?
2153 WAINWRIGHT COURT APT BA	21703	U.S.A.

11. Maritel Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Was Decedenf of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Yeer or Dates:	1☐Yes 2☒No Specify:	Specify: BLACK

15. Decedent's Eduction (Specify only highest grede completed)		16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12 TH		HOMEKEEPER	HOME

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surneme)
CARL L. BROOKS	HELEN DIGGS

19e. Informent's Neme/Reletionship (Type, Print)	19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code)
DAVID LEE WATTS	5821 BARTONSVILLE RD. FREDERICK, MD. 21704

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory, or other place)	Date	20c. Location - City or Town, State
1☒Buriel 2☐Cremetion 3☐Removal from State 4☐Donetion 5☐Other (Specify)	BARTONSVILLE CEM.	NOV. 20, 1998	BARTONSVILLE MD.

21. Signature of Funeral Service Licensee	22. Name end Address of Facility
▶ Gary L. Rollins	GARY L. ROLLINS FUNERAL HOME 21701 110 WEST SOUTH ST. FREDERICK, MD.

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximete Interel Between Onset end Death
Immediate Cause (Finel diseese or condition resulting in deeth)	e. ADENOCARCINOMA METASTATIC TO LUNGS, UNKNOWN PRIMARY SITE	2 MONTHS
	Due to (or es e consequence of):	
Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated evenfs resulting in death) Lest	b. Due to (or es e consequence of):	
	c. Due fo (or es e consequence of):	
	d.	

Pert II. **Other eignificant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Wes en eutopsy performed?	24b. Were eutopsy findings eveilable prior to completion of cause of deeth?
1☐Yes 2☒No	1☐Yes 2☐No

25. Wes cese referred to medical examiner?	26. Plece of Deeth (Check only one)	
1☐Yes 2☒No	Hospitel: 1☒Inpetient 2☐ER/Outpetient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Deeth	28e. Dete of Injury (Month, Dey Yeer)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1☒Netural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigation 6☐Could not be determined		M	1☐Yes 2☐No	
	28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)			28f. Location (Street end Number or Rurel Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☒ **Certifying Physician**: To the best of my knowledge, death occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted.
2☐ **Medical Examiner**: On the basis of examination end/or investigetion, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) end manner stated.

29b. Signeture end title of certifier	29c. License number	29d. Date signed (Month, Dey, Yeer)
▶ MD	D47611	11-16-98

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print)
NEIL WAGANDIECHT MD 1475 TANEY AVE #204 FREDERICK MD 21702

State Registrar

31. Date filed (Month, Dey, Yeer)	32. Registrer's Signeture
NOV 19 1998	▶ Geneva G. Sparks

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Maryland Department of Health end Mental Hygiene.
Important: If item 27 is merkde other than "netural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funerel director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37006

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Rita Jean Wilt

2. Date of Death — Month: November, Day: 20, Year: 1998

3. Time of Death: 2305p.m.

4a. Facility Name (If not institution, give street and number): Sacred Heart Hospital

4b. City, Town, or Location of Death: Cumberland

4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 200-24-3987

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 64 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug 20, 1934

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: MD

10b. County: Garrett

10c. City, Town or Location: Grantsville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3648 Bear Hill Road

10f. Zip Code: 21536

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 th — College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Seamstress

16b. Kind of Business/Industry: Shirt Manufacturing

17. Father's Name (First, Middle, Last): Howard Bittner

18. Mother's Name (First, Middle, Maiden Surname): Mary Hersh

19a. Informant's Name/Relationship (Type, Print): Barbara Spiker/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 784, Grantsville, MD 21536

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Bittinger Cem. — Date: Nov 23, 1998

20c. Location - City or Town, State: Bittinger, MD

21. Signature of Funeral Service Licensee: D Jean Newman

22. Name and Address of Facility: Newman Funeral Homes, P.A., P.O. Box 275 179 Miller St., Grantsville, MD 21536

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Respiratory failure — 10 minutes

Due to (or as a consequence of):
b. Chronic Obstructive Pulmonary Disease — 10 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Peripheral Vascular Disease
Diabetes Mellitus
Atrial Fibrillation

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD MEDICAL DOCTOR

29c. License number: D31875

29d. Date signed (Month, Day, Year): Nov. 23, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Robert Welik. MD. 902 Seton Drive Cumberland MD 21502.

State Registrar

31. Date filed (Month, Day, Year): NOV 24 1998

32. Registrar's Signature: Geneva B. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Rufus W. West

2. Date of Death Month / Day / Year: Nov 16 - 18 1948

3. Time of Deeth: 1847

4e. Facility Name *(If not institution, give street end number)*: Union Hospital of Cecil County

4b. City, Town, or Location of Death: Elkton

4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 225-40-4196

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. lest birthday)*: 64 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Dey, Year)*: February 13, 1934

9. Birthplace *(Stete or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Cecil

10c. City, Town or Location: Elkton

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 10 Rock Creek Drive

10f. Zip Code: 21921

10g. Citizen of Whet Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U,S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: US Army 1956-1958

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 10 / College (1-4or 5+):

16a. Decedent's Usual Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Carpenter

16b. Kind of Business/Industry: Mobil Home Manufacturer

17. Father's Name *(First, Middle, Last)*: Richard West

18. Mother's Name *(First, Middle, Maiden Surneme)*: Jane Bledsoe

19a. Informant's Name/Relationship *(Type, Print)*: Reeble Sue West / Spouse

19b. Malling Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 10 Rock Creek Drive, Elkton, MD 21921

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Neme of cemetery, cremetory or other place)*: Whitaker Cemetery

Date: Nov. 23 1998

20c. Location - City or Town, State: Jenkins, Kentucky

21. Signature of Funeral Service Licensee: Robert L. Crouch

22. Name end Address of Facility: Crouch Funeral Home 127 South Main Street, North Esat, MD 21901

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line.

Approximete Intervel Between Onset end Death

Immediete Cause (Final disease or condition resulting in death)

e. Ventricular Fibrillation with Cardiac Arrest / Hours

Due fo (or es e consequence of):

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury thet initiated events resulting in death) Last

b. 2° to Coronary Artery Disease 6 months

Due to (or es e consequence of):

c. Inferior Wall MI 6 months ago

Due to (or as e consequence of):

d.

Part II. **Other eignificent conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.

Hypertension

Arteriosclerosis

23b. Did tobecco use contribute to the cause of death? 1☐ Yee 2☐ No 3☐ Probably 4☐ Unknown

24a. Was en eutopsy performed? 1☐ Yes 2☐ No

24b. Were eutopsy findings eveileble prior fo completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical exeminer? 1☐ Yes 2☐ No

26. Place of Death *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ E.R./Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Deeth: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end place, end due to the ceuse(s) end menner es stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Jayantilal C. Patel MD

29c. License number: D22307

29d. Date signed *(Month, Day, Yeer)*: 11/19/98

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print): JAYANTILAL C PATEL MD 123 Singerly Ave, ELKTON, MD 21921

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 20 1998

32. Registrar's Signeture: Bonnie G. Sparks

DHMH 16 Rev 6/95

West, Rufus

12 + 1

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37080

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Morris Elmer Warrington
2. Date of Death Month Day Yeer: November 17, 1998
3. Time of Death: 1245
4a Facility Name *(If not institution, give street end number)*: 167 Pleasant Hill Drive
4b. City, Town, or Location of Death: Elkton
4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 214-16-8849
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 95 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Day, Year)*: January 12, 1903
9. Birthplace *(Stete or Foreign Country)*: Maryland

Usual Residence of Decedent

10e. State: Maryland
10b. County: Cecil
10c. City, Town or Location: Elkton
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 167 Pleasant Hill Drive
10f. Zip Code: 21921
10g. Citizen of What Country?: United States

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 7 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Manager Heating and Air Conditioning
16b. Kind of Business/Industry: United States Government

17. Father's Neme *(First, Middle, Last)*: John William Warrington
18. Mother's Name *(First, Middle, Malden Surname)*: Hester Ann Potts

19a. Informant's Name/Relationship *(Type, Print)*: George P. Warrington
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 1816 Flint Hill Road, Landenberg, Pennsylvania 19350

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Placa of Disposition *(Name of cemetery, crematory or other placa)*: Cherry Hill Methodist Cemetery
Dete: November 21, 1998
20c. Location - City or Town, Stete: Cherry Hill, Maryland

21. Signature of Funeral Service Licensee: ▶ Donald S. Hicks
22. Name and Address of Facility: Hicks Home for Funerals, P.A. 103 West Stockton Street, Elkton, Maryland 21921

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death)
a. Chronic Pancreatitis — 2 years
Due to (or as e consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last
b.
Due to (or as e consequenca of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Hypertension, ATrial Fibrillation, Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Piece of Deeth *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28e. Dete of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Placa of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) and manner es stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and placa, and due to the cause(s) and manner stated.
29b. Signeture end title of certifier: ▶ Monte Makous, MD
29c. License number: D-44783
29d. Date signed *(Month, Day, Year)*: November 20, 1998

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): MONTE MAKOUS, MD 111 West High Street, ELKTON, MD 21921

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 20 1998
32. Registrar's Signeture: Barbara B. Sparks

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Nama *(First, Middle, Last)*: Elizabeth Louise WAGNER
2. Data of Death Month / Day / Yaer: Nov 20 1998
3. Tima of Death: 8:50 a. m.
4a. Facility Nama *(If not institution, giva straat and number)*: Homewood Retirement Center
4b. City, Town, or Location of Daath: Williamsport
4c. County of Death: Washington

Funeral Director

5. Sociel Security Numbar: 220-58-4958
6. Sax: 1☐ M 2☒ F
7. Aga *(In yrs. last birthday)*: 91 Yrs. — If Under 1 Yaar: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: May 4 1907
9. Birthplaca *(State or Foraign Country)*: Maryland

Usual Rasidance of Dacadant

10a. Stata: Maryland
10b. County: Washington
10c. City, Town or Location: Hagerstown
10d. Insida City Limits: 1☒ Yas 2☐ No
10e. Street end Number: 441 Pangborn Blvd.
10f. Zip Coda: 21742
10g. Citizan of Whet Country?: U.S.A.

11. Marital Status: 1☐ Navar Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Dacedant Evar in U.S. Armed Forces?: 1☐ Yes 2☒ No — If Yes, Giva Yeer or Datas:
13. Was Decedant of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puerto Ricen, atc.): 1☐ Yas 2☒ No *Spacify:*
14. Race - American Indien, Black, Whita, atc. *Specify:* White
15. Decedant's Eaucetion *(Specify only highast grada compliatad)*: Elementary/Secondary (0-12): 12 — Collage (1-4or 5+): 3
16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa ratired)*: Teacher
16b. Kind of Businass/Industry: School
17. Fathar's Nama *(First, Middle, Last)*: Daniel C. Snyder
18. Mothar's Nama *(First, Middle, Maiden Surnama)*: Mary Elizabeth Bush
19a. Informant's Name/Relationship *(Type, Print)*: David Wagner -Son
19b. Mailing Address *(Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: 20303 American Way Hagerstown, Maryland 21742
20a. Mathod of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Ramoval from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Nama of cematary, cramatory or other place)*: Rest Haven Cemetery — Dete: 11/23/98
20c. Location - City or Town, Stata: Hagerstown, Maryland
21. Signatura of Funerel Service Licensaa: Fred L. Weste
22. Name end Addrass of Facility: Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused tha daath. Do not enter the moda of dying, such es cardiac or raspiretory arrast, shock, or heart failura. List only one ceuse on each lina. — Approximata Intarval Batwaen Onsat end Death

Immediata Causa (Final disaase or condition rasulting in daath)
a. Congestive Heart Failure
Dua to (or as a consequance of):
Sequantielly list conditions, if any, leading to immadiata ceusa. Entar Underlying Cause (Disaasa or injury that initiated events rasulting in daath) Lest
b. Arteriosclerotic cardiovascular disease
Dua to (or as a consaquance of):
c.
Dua to (or es e consequence of):
d.

Part II. **Other significent conditione** contributing to death but not resulting in the underlying cause given in Part I.
Hypertension
Renal insufficiency

23b. Did tobacco uea contribute to the cauea of death?: 1☐ Yas 2☒ No 3☐ Probably 4☐ Unknown
24a. Was an autopsy parformed?: 1☐ Yas 2☒ No
24b. Wara autopsy findings available prior to compliation of ceusa of daath?: 1☐ Yas 2☐ No
25. Was case refarred to medical exeminar?: 1☐ Yas 2☒ No
26. Piece of Daath *(Check only one)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpatiant 3☐ DOA — Othar: 4☒ Nursing Homa 5☐ Rasidance 6☐ Other *(Specify)*
27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending Investigation 6☐ Could not be datarmined
28a. Data of Injury *(Month, Day Year)*
28b. Tima of Injury
28c. Injury at Work?: 1☐ Yas 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At homa, farm, straat, factory, office building, etc. *(Spacify)*
28f. Location *(Streat and Number or Rural Routa Number, City or Town, State)*
29a. Certifiar *(Check only one)*: 1☒ **Certifying Physician:** To tha best of my knowladga, daath occurrad at tha tima, data and place, and due to the ceuse(s) end mannar as statad. 2☐ **Medical Examinar:** On tha basis of axamination and/or Investigation, in my opinion, daath occurred et tha time, deta end place, and dua to tha causa(s) and mannar statad.
29b. Signature and title of certifier:
29c. Licensa number: D26606
29d. Data signed *(Month, Day, Year)*: 11/20/98
30. Nama and address of person who completed ceuse of death (Item 23e) (Type, Print): AMD of MS 747 Norton Ave Hagerstown MD 21742

State Registrar

31. Date filed *(Month, Day, Yaar)*: NOV 24 1998
32. Registrar's Signatura: Donna L. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

11-20-98 85A

Elizabeth Wagner

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Richard Grant WILSON
2. Dete of Death — Month: Nov. Dey: 19 Year: 1998
3. Time of Death: 4:15 P.M.
4a. Facility Name *(If not institution, give street and number)*: Homewood Retirement Center
4b. City, Town, or Location of Deeth: Williamsport
4c. County of Deeth: Washington

Funeral Director

5. Social Security Number: 217-18-7315
6. Sex: 1☒ M 2☐ F
7. Aga *(In yrs. last birthday)*: 74 Yrs. — If Under 1 Yaar: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: Aug 3 1924
9. Birthplaca *(State or Foraign Country)*: Pennsylvania

Usuel Residence of Decedent

10a. State: Maryland — 10b. County: Washington — 10c. City, Town or Location: Hagerstown — 10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 414 Liberty Street — 10f. Zip Code: 21740 — 10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1☐ Nevar Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No — If Yes, Give Yaer or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuben, Mexican, Puarto Rican, atc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indien, Black, Whita, etc. *Specify:* White

15. Decedent's Educetion *(Specify only highast grada completad)*: Elementery/Secondary (0-12): 11 — College (1-4or 5+): 0

16a. Decedent's Usuel Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa retired)*: Machinist

16b. Kind of Business/Industry: Truck Manufacturer

17. Fether's Name *(First, Middla, Last)*: Joseph Amos Wilson

18. Mother's Neme *(First, Middla, Maidan Sumama)*: Florence Rose Stalter

19a. Informant's Neme/Relationship *(Type, Print)*: Joyce Wilson - Wife

19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 414 Liberty Street Hagerstown, Maryland 21740

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Place of Disposition *(Nama of cematary, cramatory or othar place)*: Rose Hill Cemetery — Date: 11/23/98

20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funerel Service Licensee: Fred Lubiston

22. Nama and Address of Fecility: Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arresl, shock, or heert failure. List only one ceuse on eech line.

Approximate Intervel Between Onset and Deeth

Immediata Cause (Final disaesa or condition resulting in death): e. Pneumonia — Due to (or es e consequence of): — days

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury thet initieted avents resulting in death) Lest:
b. — Due to (or es e consequance of):
c. — Dua to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying cause givan in Part I.: Cerebral Hemorrhage; Diabetes Mellitus Type

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performad? 1☐ Yas 2☒ No

24b. Wara autopsy findings availabla prior to completion of cause of deeth? 1☐ Yas 2☐ No

25. Wes case rafarred to medical examiner? 1☐ Yes 2☒ No

28. Plece of Deeth *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury - *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Plece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) end menner es steted. 2☐ **Medical Examiner**: On the besis of examination and/or investigetion, in my opinion, death occurred et the time, dete end piece, end due to the cause(s) end manner steted.

29b. Signature and title of certifier:

29c. License number: D26806

29d. Date signed *(Month, Day, Year)*: 11/20/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Harold Hess 747 Northern Ave Hagerstown MD 21742

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 20 1998

32. Registrars Signature: P. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires thet tha death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

11-19-98

Richard Wilson

45 45

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37091

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARGARET ELIZABETH WILLIAMS
2. Date of Death (Month, Day, Year): November 11 1998
3. Time of Death: 1957
4a. Facility Name (If not institution, give street and number): Washington County Hospital
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 214-09-8731
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 82 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): August 15, 1916
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Washington
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 19921 Trengail Road
10f. Zip Code: 21742
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Lest): Tyson Raymond Waltz
18. Mother's Name (First, Middle, Maiden Surname): Beulah Mae Shilling

19a. Informant's Name/Relationship (Type, Print): George P. Williams
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 19921 Trengail Road, Hagerstown, Maryland 21742

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Cedar Lawn Memorial Park
Date: 11-16-98
20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: ▶ R. Noel Brady
22. Name and Address of Facility: Andrew K. Coffman Funeral Home, Inc. 40 East Antietam Street, Hagerstown, Md. 21740

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death)
a. Acute Myocardial Infarction — 2 HRS
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. ATHROSCLEROTIC CARDIOVASCULAR DISEASE — YRS
Due to (or es e consequence of):
c.
Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy tindings available prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Was cese referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, dete end place, end due to the ceuse(s) end manner es steted. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture and title of certifier: ▶ [signature]
29c. License number: D14996
29d. Date signed (Month, Day, Year): NOV 12, 1998

30. Name end address of person who completed ceuse of death (Item 23a) (Type, Print): Z. Malik MD 20311 Lappans Rd Boonsboro MD 21713

State Registrar

31. Date tiled (Month, Day, Year): NOV 13 1998
32. Registrar's Signature: ▶ Penina G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Meryland Department of Health end Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate hes been signed by the attending physician end completely filled in by the funeral director, pege 2 should be detached for use as the burial-transit permit.

Margaret E. Williams

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Catherine Louise Winfield

2. Date of Death (Month, Day, Year): November 6 1998

3. Time of Death: 07:35

4a. Facility Name *(If not institution, give street and number)*: Washington County Hospital

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 218-34-2823

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 60 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Feb. 4, 1938

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Md.

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 611 W. Church St.

10f. Zip Code: 21740

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Dietition

16b. Kind of Business/Industry: Nursing Home

17. Father's Name *(First, Middle, Last)*: Robert L. West

18. Mother's Name *(First, Middle, Maiden Surname)*: Laura V. Law

19a. Informant's Name/Relationship *(Type, Print)*: Jessie L. Lowery (Daughter)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 613 W. Church St. Hagerstown, Md. 21740

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Garfield U.M. Cemetery

Date: Nov. 9, 1998

20c. Location - City or Town, State: Garfield, Md.

21. Signature of Funeral Service Licensee: Dennis L. Davis

22. Name and Address of Facility: Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Md. 21783

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset end Death
Immediate Cause (Final diseese or condition resulting in death) e.	lung Cancer	(4) Month
Due to (or es e consequence of):		
b.	PNEUMONIA.	(4) day
Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury thet initieted events resulting in death) Lest — Due to (or es e consequence of): c.	Superior Vena Cava Syndrome	(3) weeks
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☑ **Yes** 2☐ **No** 3☐ **Probably** 4☐ **Unknown**

24a. Wes en eutopsy performed? 1☐ Yes 2☑ No

24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Wes cese referred to medicel examiner? 1☐ Yes 2☑ No

26. Piece of Deeth *(Check only one)*: Hospitel: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Deeth: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Phyeicien:** To the best of my knowledge, death occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Exeminer:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, and due to the ceuse(s) end menner stated.

29b. Signature end title of certifier: MD

29c. License number: D 47288

29d. Date signed *(Month, Dey, Year)*: 11, 10, 98

30. Neme end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print): Dr Iqbal 12821 Oak Hill Avenue Hagerstown Maryland

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 10 1998

32. Registrar's Signature: Denise G. Sparks

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Catherine Louise Winfield

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37093

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Dete of Deeth Month Dey Yeer	3. Time of Deeth
ROSE MARIE YOB	November 18, 1998	4:15 AM

4e Fecility Neme (If not institution, give street end number)	4b. City, Town, or Location of Deeth	4c. County of Deeth
NORTHAMPTON MANOR NURSING HOME	FREDERICK	FREDERICK

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. lest birthday)	If Under 1 Year Months / Deys	If Under 24 Hrs. Hours / Min.	8. Date of Birth (Month, Dey, Yeer)	9. Birthplace (Stete or Foreign Country)
003-10-9494	1☐ M 2☒ F	76 Yrs.			May 7, 1922	New Hampshire

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Frederick	Frederick	1☒ Yes 2☐ No

10e. Street end Number	10f. Zip Code	10g. Citizen of Whet Country?
799 C Wembley Drive	21701	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Yeer or Dates:	1☐ Yes 2☒ No Specify:	Specify: white

15. Decedent's Education (Specify only highest grede completed)		16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10	-	Manager	Public Storage

17. Fether's Neme (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surneme)
Nestor Vanasse	Clara Ruel Vanasse

19a. Informent's Name/Relationship (Type, Print)	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)
Theresa Olszewski / daughter	798 B Wembly Drive, Frederick, MD 21701

20e. Method of Disposition	20b. Plece of Disposition (Neme of cemetery, cremetory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Hagerstown Crematory	11/19/98	Hagerstown, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Raymond Peterson	Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, MD 21702

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on eech line.

		Approximete Interval Between Onset end Death
Immediate Cause (Finel disease or condition resulting in death)	e. Hemorrhagic Stroke	2weeks
	Due to (or es e consequence of):	
Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest	b. Hypertension	
	Due to (or as e consequence of):	
	c.	
	Due to (or es e consequence of):	
	d.	

Part II. **Other significent conditione** contributing to death but not resulting In the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed?	24b. Were eutopsy findings available prior to completion of cause of deeth?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Wes case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA	Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Dey Yeer)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) and manner es steted.
2☐ **Medical Examiner:** On the besis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) and menner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Yeer)
Ali J. Ahookteh MD	D35183	11/18/98

30. Neme end address of person who completed cause of death (Item 23e) (Type, Print)
Ali J. Ahookteh 300 W 9th St Frederick MD

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 20 1998	Denise D. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours efter death with the Marylend Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours efter death.
To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Eliot Richard YOUNG
2. Date of Death (Month, Day, Year): November 11, 1998
3. Time of Death: 5:45am
4a. Facility Name *(If not institution, give street end number)*: Northampton Manor Nursing Center
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 577-14-3561
6. Sex: 1 ☒ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 78 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Feb 12, 1920
9. Birthplace *(State or Foreign Country)*: Washington DC

Usual Residence of Decedent

10e. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street end Number: 6592 Ashford Lane
10f. Zip Code: 21702
10g. Citizen of What Country?: U.S.A.
11. Maritel Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No — If Yes, Give Year or Dates: 1943-1946
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): ; College (1-4or 5+): 2
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Investment Broker
16b. Kind of Business/Industry: Financial
17. Father's Name *(First, Middle, Last)*: Harry E McCabe
18. Mother's Name *(First, Middle, Maiden Sumame)*: Mathilde Maryellen Young
19a. Informant's Name/Relationship *(Type, Print)*: Mrs C. Louise Young/Wife
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 6592 Ashford Lane, Frederick, Maryland 21702
20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Smithsburg Crematory — Date: Nov 11,1998
20c. Location - City or Town, State: Smithsburg, Maryland
21. Signature of Funeral Service Licensee: Kathryn Roberson — M00706
22. Name end Address of Facility: Keeney & Basford P.A. Funeral Home, 106 E Church Street, Frederick, maryland 21701

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	HEPATIC ENCEPHALOPATHY	2 WKS
Due to (or as a consequence of): b.	CIRRHOSIS OF LIVER	2 YRS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Lest — Due to (or es e consequence of): c.	HEPATITIS C	5 YRS
d.		

Part II. **Other signiflcant conditions** contributing to death but not resulting in the underlying cause given in Part I.: PROSTATE Ca

23b. Did tobacco use contributa to tha cauaa of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was en eutopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings avaiiable prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medicai examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Deeth: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: Andrew O. Donelson M.D.
29c. License number: D21936
29d. Date signed *(Month, Day, Year)*: November 11,1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Andrew O. Donelson, M.D., 170 Thomas Johnson Dr, #100, Frederick, Maryland 21702

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 12 1998
32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37095

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ROBERT ADAMS
2. Date of Death: Month Dec, Day 02, Year 1998
3. Time of Death: 0155
4a. Facility Name (If not institution, give street and number): University of Maryland Hospitals 22 S. Greene St Balt Md
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: NA

Funeral Director

5. Social Security Number: 218-56-1435
6. Sex: 1☐ M 2☐ F
7. Age (In yrs. last birthday): 45 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 7/31/53
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street and Number: 4226 Lock Raven Blvd
10f. Zip Code: 21218
10g. Citizen of What Country?: USA

11. Marital Status: 1☑ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☑ Yes 2☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☑ No Specify:
14. Race - American Indien, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): ADMISSIONS ADM.
16b. Kind of Business/Industry: HOSPITAL

17. Father's Name (First, Middle, Last): unk
18. Mother's Name (First, Middle, Maiden Surname): SHIRLER BOOKER

19a. Informant's Name/Relationship (Type, Print): SON ROBERT ADAMS
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 20 N. BERNICE AVE. BALTIMORE, MD 21229

20a. Method of Disposition: 1☐ Burial 2☑ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory
Date: 12-3-98
20c. Location - City or Town, State: Catonsville, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: ALBERT P. WYLIE FUNERAL HM PA 638 N. Gilmor St. BALTIMORE, MD 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. TYPE A AORTIC DISSECTION — 8 hours

Due to (or as a consequence of):
b. Hypertension — ?

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. Right heart failure — 8 hours

Due to (or as a consequence of):
d. Coronary artery dissection — 8 hours

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Kenneth E Simm MD
29c. License number: P06030
29d. Date signed (Month, Day, Year): Dec 02 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): University of Maryland Hospitals, 22 S. Greene St Baltimore Md 21201

State Registrar

31. Date filed (Month, Day, Year): DEC 04 1998
32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37096

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EDITH MARIE BARBER
2. Date of Death: Month DECEMBER Day 3, Year 1998
3. Time of Death: 1PM
4a. Facility Name (If not institution, give street and number): 5930 CENTRAL AVE.
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 209 24 1259
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 66 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 3, 1932
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Insida City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 5930 Central Ave.
10f. Zip Code: 21207
10g. Citizen of What Country?: United States

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Black, Whita, atc. Specify: White

15. Decedent's Education (Specify only highest grada completed): Elementary/Secondary (0-12): 9 | College (1-4or 5+):
16a. Decedent's Usuat Occupation (Give kind of work dona during most of working life. DO NOT use retired): Proprietor
16b. Kind of Business/Industry: Restaurant

17. Fethar's Name (First, Middle, Last): Albert W. Barber
18. Mother's Name (First, Middle, Maiden Sumame): Thelma E. Geisel

19a. Informant's Neme/Retetionship (Type, Print): William L. Brainer / Personal Representative
19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code): 5930 Central Ave., Baltimore, MD 21207

20a. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removal from Stete 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Nama of cematery, crematory or other place): Green Mount Crematory | Date: 12/4/98
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Stephen D Lohrmann
22. Name end Address of Fecility: CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Dr., Baltimore, MD 21286

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or raspiratory errest, shock, or heart feilure. List only one cause on each line.

Approximate Interval Between Onsat and Death

Immedieta Cause (Final disease or condition resulting in death): e. Cerebrovascular Accident — 2 hours

Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last:
b. Cerebrovascular Insufficiency
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Ischemic Cardiomyopathy. Severe Emphysema. Acute and Chronic Renal Failure. Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to complation of causa of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Deeth (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end menner es stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigetion, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ATTENDING
29c. License number: D16200
29d. Date signed (Month, Day, Year): DECEMBER 4, 1998

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print): DR. NORBERTO M. MACHIRAN 720-C MAIDEN CHOICE LA. BALTO. MD, 21228

State Registrar

31. Data filed (Month, Day, Year): DEC 04 1998
32. Registrer's Signeture: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet tha death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

98-6965-033
crn
Norval Brooks, Jr.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37097

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Norval Ray Brooks, Jr.

2. Date of Death (Month, Day, Year): November 30, 1998

3. Time of Death: 7:20 P.M.

4a. Facility Name (If not institution, give street and number): Rt. 495 @ Kennilworth Avenue

4b. City, Town, or Location of Death: Greenbelt

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 578-44-9459

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 62 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan 29, 1936

9. Birthplace (State or Foreign Country): VA

Usual Residence of Decedent

10a. State: DE

10b. County: Kent

10c. City, Town or Location: Harrington

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 5033 Milford Harrington Hwy

10f. Zip Code: 19952

10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7 | College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Owner / Operator

16b. Kind of Business/Industry: Bus Transportation

17. Father's Name (First, Middle, Last): Norval R. Brooks

18. Mother's Name (First, Middle, Maiden Surname): Annie V. Kearns

19a. Informant's Name/Relationship (Type, Print): Peggy T. Brooks / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5033 Milford Harrington Hwy, Harrington DE 19952

20a. Method of Disposition: 1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Hollywood Cemetery, Date: December 8, 1998

20c. Location - City or Town, State: Harrington 19952 DE

21. Signature of Funeral Service Licensee: Victor P. Doda, Jr.

22. Name and Address of Facility: Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 21230

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Multiple Injuries

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) at scene

27. Manner of Death: 1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year): 11/30/98

28b. Time of Injury: unknown M

28c. Injury at Work? 1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred: subject thrown out back of bus

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): roadway

28f. Location (Street and Number or Rural Route Number, City or Town, State): Route 50 at Kenilworth Avenue Prince Georges County Maryland

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Theodore M. King MD

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): December 01, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): DEC 04 1998

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37098

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Irene F. Berube

2. Dete of Death Month Dey Year: Dec. 1, 1998

3. Time of Death: 9:10pm

4e Facility Neme *(If not institution, give street and number)*: Golden Oaks Nursing Home

4b. City, Town, or Location of Deeth: Laurel, MD

4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 016-09-1986

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthdey)*: 82 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Day, Year)*: Sept. 19, 1916

9. Birthplace *(State or Foreign Country)*: MA

Usuel Residence of Decedent

10e. Stete: MD

10b. County: Prince Georges

10c. City, Town or Location: Laurel

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 6201 Kaybro Street

10f. Zip Code: 20707

10g. Citizen of Whet Country?: USA

11. Meritel Stetus: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grede completed)*: Elementery/Secondery (0-12): 12 | College (1-4or 5+): 0

16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Housekeeper

16b. Kind of Business/Industry: Private Home

17. Fether's Neme *(First, Middle, Last)*: Adelard Jodoin

18. Mother's Neme *(First, Middle, Maiden Surname)*: Josephine Thibadeau

19e. Informent's Neme/Reletionship *(Type, Print)*: Doris Richard /Daughter

19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6201 Kaybro Street, Laurel Maryland 20707

20e. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Name of cemetery, crematory or other place)*: Green Mount Crematory | Date: December 3, 1998

20c. Location - City or Town, State: Baltimore City

21. Signature of Funeral Service Licensee: Victor P. Doda, Jr. ▶ Victor P. Doda, Jr.

22. Name and Address of Feeility: Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore MD 21230

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heart failure. List only one ceuse on eech line.

		Approximate Interval Between Onset end Death
Immediete Ceuse (Finel diseese or condition resulting in deeth)	e. Renal Failure	1 week
	Due to (or es e consequence of):	
Sequentially list conditions, if eny, ieeding to immediete ceuse. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Lest	b. Myocardial Infarction	2 weeks
	Due to (or es e consequence of):	
	c.	
	Due to (or es e consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes an eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings aveilable prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Dete of Injury *(Month, Day Yeer)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner**: On the basis of exeminetion end/or investigetion, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) end menner steted.

29b. Signature end title of certifier: ▶ Andrew Kunonga M.D.

29c. License number: D36716

29d. Dete signed *(Month, Day, Year)*: December 2, 1998

30. Neme end eddress of person who completed ceuse of deeth (Item 23a) (Type, Print): Andrew Kunonga, M.D. 8317 Cherry Lane, Laurel, Md 20707

State Registrar

31. Dete filed *(Month, Day, Year)*: DEC 04 1998

32. Registrer's Signature: ▶ G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37099

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Marion Joseph Bertrand
2. Data of Death Month / Day / Yaar: December 1, 1998
3. Tima of Death: 11:20 P.M.
4a Facility Nama (If not institution, give street end number): 831 N. Lakewood Avenue
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-12-3909
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 82 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Year): Sept. 27, 1915
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. Stata: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 831 N. Lakewood Avenue
10f. Zip Code: 21205
10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1☐ Naver Married 2☒ Marriad 3☐ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forcas? 1☒ Yes 2☐ No If Yes, Giva Yaar or Dates: 1945-1946
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, Whita, atc. Specify: White

15. Decedent's Educatlon (Specify only highest grade completad): Elementery/Secondary (0-12): 8th Grade — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Clerk/Receiving Department
16b. Kind of Business/Industry: Martin's

17. Fethar's Name (First, Middla, Last): John Bertrand
18. Mother's Name (First, Middla, Maidan Surname): Barbara Kuzel

19a. Informant's Name/Relationship (Type, Print): Tillie B. Bertrand (Wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 831 N. Lakewood Avenue, Baltimore, Maryalnd 21205

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Most Holy Redeemer
Date: 12/5/98
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Mark T. Zaruba
22. Name and Address of Facility: Schimunek Funeral Home Inc. 3331 Brehms Lane, Baltimore, Maryland 21213

Physician /Medical Examiner

23a. Part1. Entar the disease, or complications that caused the death. Do not enter the moda of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Adenocarcinoma Stomach — 3mos
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequenca of):
d.

Part II. **Othar significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performad? 1☐ Yas 2☑ No
24b. Wara autopsy findings available prior to completion of causa of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yas 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☑ Residance 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) end manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Robert C. Irwin MD
29c. Licanse number: D08900
29d. Data signed (Month, Dey, Year): 12-2-98
30. Name and address of person who completed ceusa of daath (Item 23a) (Type, Print): Robert C. Irwin MD 858 N. Eutaw St. Balto Md 21201

State Registrar

31. Date filed (Month, Day, Year): DEC 04 1998
32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Haalth and Mental Hygiana. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that tha death certificate be executed within 24 hours after death.
To the Funeral Director: Aftar this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37100

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lucille M. Berlin
2. Date of Death Month Day Year: Dec. 3 1998
3. Time of Death: 7:50 A.M.

4a. Facility Name (If not institution, give street and number): Crofton Convalescent Center
4b. City, Town, or Location of Death: Crofton
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 212 64 5215
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 76 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): August 8, 1922
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Bowie
10d. Inside City Limits: ☒ 1 Yes 2☐ No
10e. Street and Number: 12401 Melody Turn
10f. Zip Code: 20715
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☐ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Albert Harbaugh
18. Mother's Name (First, Middle, Maiden Surname): Bessie Mouth

19a. Informant's Name/Relationship (Type, Print): William Berlin Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12401 Melody Turn Bowie Maryland 20715

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Harbaugh Church Cemetery | Date: Dec. 5, 1998
20c. Location - City or Town, State: Rouzerville PA

21. Signature of Funeral Service Licensee: ▶ Michael L Bigler
22. Name and Address of Facility: Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Congestive Heart Failure
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: COPD

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) end menner es steted. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ MD
29c. License number: D35848
29d. Date signed (Month, Day, Year): Dec 4, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Howard K Schultz Jr. 1438 Defense Hwy Gambrills, MD 21054

State Registrar

31. Date filed (Month, Day, Year): DEC 04 1998
32. Registrar's Signature: ▶ Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37101

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Mildred U. Bleile

2. Dete of Death — Month: Nov. Dey: 30 Year: 1998

3. Time of Death: 3:40 P.M.

4a. Facility Neme (If not institution, give street end number): Crofton Convalescent Center

4b. City, Town, or Location of Death: Crofton

4c. County of Deeth: Anne Arundel

Funeral Director

5. Social Security Number: 195 14 3215

6. Sex: 1☐ M 2☐ F (XX)

7. Age (In yrs. last birthday): 74 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 11, 1924

9. Birthplace (State or Foreign Country): Oklahoma

Usuel Residence of Decedent

10a. Stete: Maryland

10b. County: Prince George's

10c. City, Town or Location: Bowie

10d. Inside City Limits: ☒ Yes 2☐ No

10e. Street and Number: 12508 Starlight Lane

10f. Zip Code: 20715

10g. Citizen of Whet Country?: United States

11. Maritel Stetus: 1☐ Never Merried 2☐ Married 3☐ Widowed 4☒ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12 — College (1-4or 5+): 0

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Owner

16b. Kind of Business/Industry: Retail Clothing

17. Fether's Neme (First, Middle, Last): Ralph S. Johns

18. Mother's Neme (First, Middle, Maiden Surneme): Una M. Reid

19e. Informent's Neme/Reletionship (Type, Print): Henry R. Bleile Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12508 Starlight Lane Bowie Maryland 20715

20e. Method of Disposition: 1☐ Buriel 2☒ Cremation 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other piece): Metropolitan Crematory — Date: Dec. 2, 1998

20c. Location - City or Town, Stete: Alexandria Virginia

21. Signeture of Funerel Service Licensee: James R Evans

22. Neme and Address of Facility: Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heert feilure. List only one cause on eech line.

		Approximete Interval Between Onset end Death
Immediate Cause (Final disease or condition resulting in death) e.	Pulmonary Hypertension	1 year
Due to (or es a consequence of):		
b.	Scleroderma	10 years
Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in death) Last — Due to (or es e consequence of):		
c.		
Due to (or es e consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☑ No

24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Deeth (Check only one) — Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA — Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☑ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Yeer)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end manner es steted. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) end manner stated.

29b. Signeture end title of certifier: MD

29c. License number: D 50343

29d. Date signed (Month, Dey, Yeer): December 1, 1998

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print): Kelvin Hao MD 3231 Superior Lane Suite A-6 Bowie, Maryland 20715

State Registrar

31. Dete filed (Month, Dey, Yeer): DEC 04 1998

32. Registrar's Signature: Denise G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37102

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Darnell B Boyd
2. Date of Death (Month, Day, Year): November 30 1998
3. Time of Death: 20:57
4a. Facility Name (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-84-6111
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 25 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 21,1973
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE CITY
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street end Number: 2326 DRUID PARK DRIVE
10f. Zip Code: 21215
10g. Citizen of Whet Country?: U.S.A

11. Marital Stetus: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indien, Bleck, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): DISABLE
16b. Kind of Business/Industry: N/A

17. Father's Name (First, Middle, Last): ISSAC GUNTHER
18. Mother's Name (First, Middle, Maiden Surname): ROSE E. BOYD

19a. Informant's Name/Reletionship (Type, Print): ROSE E. BOYD
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 2326 DRUID PARK DRIVE BALTIMORE, MD 21215

20a. Method of Disposition: 1 [X] Buriel 2 [ ] Cremetion 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Piece of Disposition (Name of cemetery, cremetory or other piece): KING MEMORIAL PARK
Date: 12/4/98
20c. Location - City or Town, Stete: Woodlawn, MD

21. Signature of Funeral Service Licensee: Barbara A. [illegible]
22. Name and Address of Facility: WILLIAM C. BROWN COMMUNITY FUNERAL HOME P.A. 1206 W. NORTH AVE.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart feilure. List only one cause on eech line.

Approximate Interval Between Onset end Death

Immediate Ceuse (Finel disease or condition resulting in death): e. Pulmonary Congestion — 2 days
Due to (or es e consequence of):
Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last:
b. Chronic renal failure — 1 year
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Hypertension

23b. Did tobacco uee contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No
24b. Were eutopsy findings eveilable prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospitel: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined
28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end place, and due to the ceuse(s) and manner es steted. 2 [ ] **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end menner steted.

29b. Signature end title of certifier: [signature]
29c. License number: RES-000
29d. Date signed (Month, Day, Year): November 30, 1998

30. Neme end address of person who completed cause of death (Item 23a) (Type, Print): Derek Taylor Johns Hopkins Hosp. Tower 110 Baltimore, MD 21287

State Registrar

31. Dete filed (Month, Dey, Yeer): DEC 04 1998
32. Registrer's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

UR 2

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item 5 Per FH Film G766 12-16-98 rja

Certificate of Death

Reg. No. 98 37103

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: CAROLYN STERNS BOTELLE

2. Date of Death (Month, Day, Year): November 29, 1998

3. Time of Death: 08:58

4e. Facility Name *(If not institution, give street and number)*: Sinai Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: ~~040-24-9486~~ 046-22-0524

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 68 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Oct. 12, 1930

9. Birthplace *(State or Foreign Country)*: CT

Usual Residence of Decedent

10a. State: MD

10b. County: Harford

10c. City, Town or Location: Abingdon

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3753 Wolf Trail Drive

10f. Zip Code: 21009

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Telephone Operator

16b. Kind of Business/Industry: Hospital

17. Father's Name *(First, Middle, Last)*: Edwin E. Sterns

18. Mother's Name *(First, Middle, Maiden Surname)*: Pattie Johnson

19a. Informant's Name/Relationship *(Type, Print)*: James A. Botelle Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 203 New Ave., Reisterstown, Md. 21136

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Carroll Cremation

Date: 11/30/98

20c. Location - City or Town, State: Hampstead, Md.

21. Signature of Funeral Service Licensee: Frank B. Eline

22. Name and Address of Facility: Eline Funeral Home, 11824 Reisterstown Rd. Reisterstown, Md. 21136

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Known as Carol Botelle

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Aspiration Pneumonia	One week
Due to (or as a consequence of):	b. Anoxic brain injury	one month
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Cardiac arrest	one month
Due to (or as a consequence of):	d. Arteriosclerotic disease	years

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Dawn Dillman Ewing MD

29c. Licensa number: P12315

29d. Date signed *(Month, Day, Year)*: November 29, 1998

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Dawn Dillman Ewing, MD

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 04 1998

32. Registrar's Signature: Joyce P. Sparks

DHMH 16 Rev 6/95

98-6959-510
CMK
UNK.#98-268
JOSEPH BROWN

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37104

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOSEPH HAYES BROWN
2. Date of Death (Month, Day, Year): NOVEMBER 30, 1998
3. Time of Death: 0712AM
4a. Facility Name (If not institution, give street and number): REAR OF 6001 BELAIR ROAD
4b. City, Town, or Location of Death: BALTIMORE CITY
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-88-9619
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 35 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 6/29/1963
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☐ Yes 2 ☐ No
10e. Street and Number: 5913 Kavon Avenue
10f. Zip Code: 21206
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Electrician
16b. Kind of Business/Industry: Unknown

17. Father's Name (First, Middle, Last): Richard Brown
18. Mother's Name (First, Middle, Maiden Surname): Martha Hayes

19a. Informent's Name/Reletionship (Type, Print): Richard Brown /Father
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5913 Kavon Avenue Baltimore, Maryland 21206

20a. Method of Disposition: 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Moreland Memorial | Dete: 12/4/98
20c. Location - City or Town, Stete: Baltimore, Maryland

21. Signeture of Funeral Service Licensee: Juanita R Thomas
22. Name end Address of Facility: John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206

Physician /Medical Examiner

23a. Pert1 Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on eech line. | Approximete Interval Between Onset end Death

Immediate Ceuse (Final disease or condition resulting in deeth)
a. Bluntand Sharp Force Injuries
Due to (or es a consequence of):

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in death) Lest
b.
Due to (or as e consequence of):
c.
Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Wes an eutopsy performed? 1 ☒ Yes 2 ☐ No
24b. Were eutopsy findings available prior to completion of cause of death? 1 ☑ Yes 2 ☐ No

25. Wes case referred to medical examiner? 1 ☒ Yes 2 ☐ No
26. Place of Deeth (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) AT SCENE

27. Menner of Deeth: 1 ☐ Netural 2 ☐ Accident 3 ☐ Suicide 4 ☒ Homicide 5 ☐ Pending investigetion 6 ☐ Could not be determined
28a. Dete of Injury (Month, Dey Year): Found 11-30-98
28b. Time of Injury: Found 2004 M
28c. Injury et Work? 1 ☐ Yes 2 ☒ No
28d. Describe how injury occurred: subject cut and beaten
28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify): street
28f. Location (Street and Number or Rural Route Number, City or Town, State): 6001 Belair Road Baltimore, Md

29a. Certifier (Check only one): 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) end manner as stated. 2 ☒ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end plece, end due to the cause(s) end menner steted.
29b. Signature and title of certifier: Dennis J. Chute MD
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): DECEMBER 01, 1998
30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): Dennis J. Chute, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed (Month, Day, Year): DEC 04 1998
32. Registrer's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 37105

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DANIEL W. CLARK
2. Date of Death (Month, Dey, Yeer): Dezember 1 1998
3. Time of Death: 18:45
4a. Facility Neme (If not institution, give street end number): Good Samaritan Hospital
4b. City, Town, or Location of Deeth: Baltimore
4c. County of Deeth: N/A

Funeral Director

5. Sociel Security Number: 212-03-4818
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthdey): 80 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Yeer): Jan. 3, 1918
9. Birthplece (Stete or Foreign Country): Maryland

Usual Residenca of Decedent

10a. Stete: Maryland
10b. County: N/A
10c. City, Town or Locetion: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street end Number: 3923 Dudley Avenue
10f. Zip Code: 21213
10g. Citizen of Whet Country?: U. S. A.
11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Yeer or Dates:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Bleck, White, etc. Specify: White
15. Decedent's Education (Specify only highest grede completed): Elementary/Secondery (0-12): 12th Grade — College (1-4or 5+):
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Master Machinist
16b. Kind of Business/Industry: Aerospace Defense Corporation
17. Fether's Neme (First, Middle, Last): Frank Clark
18. Mother's Name (First, Middle, Meiden Surneme): Esther Taylor
19e. Informent's Name/Relationship (Type, Print): Mildred L. Clark (Wife)
19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 3923 Dudley Avenue, Baltimore, Maryland 21213
20a. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other place): Green Mount Crematory
Date: 12/3/98
20c. Location - City or Town, State: Baltimore, Maryland
21. Signature of Funeral Service Licensee: ▶ Brian A Wellen
22. Name and Address of Facility: Schimunek Funeral Home Inc. 3331 Brehms Lane, Baltimore, Maryland 21213

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one cause on eech line.

Approximate Interval Between Onset end Deeth

Immediate Ceuse (Final diseese or condition resulting in deeth)
e. Aspiration pneumonia — 4 days
Due to (or es e consequence of):
Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Lest
b. Ischemic Cardiomyopathy — many years.
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uae contribute to the cauae of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveilable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospitel: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Yeer)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Phyaicien:** To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the ceuse(s) end manner es steted. 2☐ **Medicel Examiner:** On the basis of exemination end/or Investigation, in my opinion, deeth occurred et the time, dete end pleca, end due to the ceuse(s) and manner stated.

29b. Signature end title of certifier: ▶ Ramin ALTAHA M.D.
29c. License number: P 12555
29d. Date signed (Month, Dey, Yeer): Dez., 1 . 1998

30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print): Ramin ALTAHA, M.D. Good Samaritan Hosp. 5601 Loch Raven Blvd. Baltimore, MD 21239-2995

State Registrar

31. Date filed (Month, Dey, Yeer): DEC 04 1998
32. Registrer's Signeture: Bebra G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Heelth end Mental Hygiene.
Important: If item 27 is marked other than "natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37106

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): PAULINE CHILDRESS
2. Data of Deeth — Month: DECEMBER Day: 2 Yaar: 1998
3. Time of Death: 1050 AM
4a. Facility Neme (If not institution, give street end number): NORTHWEST HOSPITAL
4b. City, Town, or Location of Daath: RANDALLSTOWN
4c. County of Deeth: BALTIMORE

Funeral Director

5. Social Security Number: 213-14-4655
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 79 Yrs. — If Under 1 Yeer: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Dey, Yeer): 10-8-1919
9. Birthpleca (Stete or Foreign Country): Md

Usuel Residence of Decedent

10a. State: Md
10b. County: Balto
10c. City, Town or Location: Woodlawn
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3138 Jeffland Road
10f. Zip Code: 21244
10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1☐ Naver Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Evar in U.S. Armed Forcas? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuben, Mexicen, Puerto Rican, etc.): 1☐ Yas 2☒ No Specify:
14. Race - Amarican Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grede completed) — Elementary/Secondary (0-12): 12th grade — College (1-4or 5+): 2 years
16a. Decedent's Usuel Occupation (Give kind of work dona during most of working life. DO NOT use retired): Medical Intake
16b. Kind of Business/Industry: Social Security

17. Father's Name (First, Middle, Last): Luke Floyd
18. Mother's Name (First, Middle, Maiden Sumeme): Mary Gray

19a. Informant's Name/Relationship (Type, Print): Floyd B. Sims, Jr - Son
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 7608 N. Schoolhouse Road Sykesville, Md 21784

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Othar (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other place): Woodlawn Cemetery — Date: 12-7-98
20c. Location - City or Town, State: Baltimore, Md

21. Signature of Funeral Service Licensee: John B. Johnson Jr.
22. Name and Address of Facility: March F. H. West, 4300 Wabash Avenue Ba Md 21215

Physician /Medical Examiner

23a. Part I. Entar the disease, or complications that caused the death. Do not enter the moda of dying, such es cardiac or respiratory arrast, shock, or heart feilure. List only one ceuse on eech line. — Approximete Interval Between Onset end Death

Immediate Ceuse (Final disease or condition resulting in death): e. CARCINOMA OF LIVER
Due to (or es e consequence of):
Sequantially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Othar significant conditions** contributing to death but not resulting in tha underlying causa givan in Part I.: HYPERTENSION, DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performad? 1☐ Yes 2☐ No
24b. Were eutopsy findings availabla prior to completion of ceuse of deeth? 1☐ Yas 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Plece of Death (Check only one) — Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Dete of Injury (Month, Day Yeer)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end plece, end due to the cause(s) end manner es steted. 2☐ **Medical Examiner:** On the besis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end manner steted.

29b. Signature and title of certifier: C. Ravi MD
29c. Licensa number: D37333
29d. Date signed (Month, Day, Year): DECEMBER 2, 1998

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print): C. RAVI MD, NHC, BALTIMORE, MD 21133

State Registrar

31. Date filed (Month, Day, Year): DEC 04 1998
32. Registrer's Signatura: Geneva G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for usa as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

10 Refs

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 37107

Certificate of Death

Reg. No.

CHITTAMS, Bernard

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

1. Decedent's Nama *(First, Middla, Last)*: Bernard Henry Chittams

2. Data of Death Month / Day / Year: November 26 98

3. Time of Death: 1215 PM

4a. Facility Nama *(If not institution, giva street and number)*: Doctors' Community Hospital

4b. City, Town, or Location of Deeth: Lanham

4c. County of Daath: Prince George's

Funeral Director

5. Social Security Numbar: 218 12 0546

6. Sax: XX 1☐M 2☐F

7. Age *(In yrs. last birthday)*: 73 Yrs.

If Under 1 Yaar: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: March 8,1925

9. Birthplace *(Stata or Foreign Country)*: Bowie Maryland

Usual Residence of Decedant

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Bowie

10d. Inside City Limits: XX Yas 2☐No

10e. Street end Number: 8622 Myrtle Ave.

10f. Zip Coda: 20715

10g. Citizan of What Country?: United States

11. Marital Status: 1☐Navar Merriad XX Marriad 3☐Widowad 4☐Divorcad

12. Was Decedant Evar in U.S. Armed Forcas? XX Yas 2☐No If Yas, Giva Yaar or Datas: WWII

13. Was Decedant of Hispanic Origin? (Spacify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐Yas XX No *Specify:*

14. Rece - American Indian, Black, White, etc. *Specify:* Black

15. Dacadant's Education *(Spacify only highast grada complatad)*: Elementary/Secondary (0-12): 11 / College (1-4or 5+): 0

16a. Decedant's Usual Occupation *(Give kind of work dona during most of working life. DO NOT usa retired)*: General Laborer

16b. Kind of Businass/Industry: Hospital

17. Fathar's Nama *(First, Middla, Last)*: Frank Chittams

18. Mothar's Nama *(First, Middla, Maiden Sumama)*: Viola Thomas

19a. Informant's Name/Ralationship *(Type, Print)*: Shirley Ann Chittams Wife

19b. Mailing Address *(Street and Number or Rural Routa Numbar, City or Town, Stata, Zip Coda)*: 8622 Myrtle Ave. Bowie Maryland 20715

20a. Mathod of Disposition: XX 1☐Burial 2☐Cramation 3☐Ramoval from Stata 4☐Donation 5☐Othar *(Specify)*

20b. Placa of Disposition *(Nama of cama/ary, cramatory or othar place)*: Ascension Catholic Church Cemetery Date: Dec. 2, 1998

20c. Location - City or Town, Stata: Bowie Maryland

21. Signature of Funaral Sarvica Licansa: ▶ Todd Liller

22. Nama and Address of Facility: Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter tha diseese, or compiications that causad the daath. Do not anter tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failure. List only ona causa on aach lina.

Approximata Intarval Batween Onset and Death

Immediata Causa (Final disaasa or condition rasulting in death)
a. Myocardial infarction — Minutes

Dua to (or as a consaquanca of):
b. Coronary artery disease — Years

Sequantially list conditions, if any, laading to immadiata cause. Entar Underlying Causa (Disease or Injury that initiated avants rasulting in deeth) Last
Due to (or as a consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying cause givan in Part I.: Diabetes mellitus, Congestive heart failure, Peripheral vascular disease, Cerebrovascular disease

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☑Probably 4☐Unknown

24a. Was an autopsy parformad? 1☐Yes 2☑No

24b. Wara autopsy findings available prior to complation of causa of daath? 1☐Yes 2☐No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☐Yas 2☑No

26. Placa of Daath *(Check only ona)*: Hospital: 1☐Inpatient 2☑ER/Outpatient 3☐DOA Other: 4☐Nursing Homa 5☐Rasidanca 6☐Other *(Specify)*

27. Mannar of Death: 1☑Natural 2☐Accident 3☐Suicida 4☐Homicida 5☐Panding invastigation 6☐Could not be datarmined

28a. Data of Injury *(Month, Day Year)*

28b. Tima of Injury

28c. Injury at Work? 1☐Yas 2☐No

28d. Dascribe how injury occurred

28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. *(Spacify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifiar *(Check only one)*: 1☑**Certifying Physician:** To the best of my knowledga, daath occurred at tha tima, dete and placa, and due to tha causa(s) and manner es steted. 2☐**Medical Examinar:** On the basis of axamination and/or invastigation, in my opinion, daath occurrad at the time, data and placa, and due to tha causa(s) and mannar statad.

29b. Signatura and titla of certifiar: ▶ Tara T. Muscovich MD

29c. Licanse number: D46992

29d. Data signed *(Month, Dey, Year)*: 11/26/98

30. Nama and address of person who completed causa of daath (Item 23a) (Type, Print): Tara T. Muscovich MD 14300 ~~Scottsdale~~ Fox La, Suite 118, Bowie MD 20716

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Dete filed *(Month, Day, Year)*: DEC 04 1998

32. Registrar's Signature: ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37108

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William Cook
2. Date of Death (Month, Day, Year): December 2, 1998
3. Time of Death: 107 AM
4a. Facility Name (If not institution, give street and number): Northwest Hospital Center
4b. City, Town, or Location of Death: Randallstown
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 220-05-5032
6. Sex: 1 X M 2 F
7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 26, 1918
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: BAltimore
10c. City, Town or Location: Glyndon
10d. Inside City Limits: 1 Yes 2 X No
10e. Street and Number: 4234 Butler Rd.
10f. Zip Code: 21071
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 Never Married 2 X Married 3 Widowed 4 Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 Yes 2 X No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Sheet Metal Fabricator
16b. Kind of Business/Industry: Johns Hopkins

17. Father's Name (First, Middle, Last): Rozell Cook
18. Mother's Name (First, Middle, Maiden Surname): Lillian Tracey

19a. Informant's Name/Relationship (Type, Print): Lois H. Cook Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4234 Butler Rd., Glyndon, Md. 21071

20a. Method of Disposition: 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Forest Baptist Cemetery | Date: 12/5/98
20c. Location - City or Town, State: Upperco, MD

21. Signature of Funeral Service Licensee: [signature] Eline
22. Name and Address of Facility: 11824 Reisterstown Rd. Eline Funeral Home Reisterstown, Md. 21136

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death)
a. ADULT RESPIRATORY DISTRESS SYNDROME — SEVERAL DAYS

Due to (or as a consequenca of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequenca of):
c.

Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
ACUTE MYOCARDIAL INFARCTION

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 X No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 X No
24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 X No

25. Was case referred to medical exeminer? 1 Yes 2 X No
26. Place of Death (Check only one): Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA | Other: 4 Nursing Home 5 Residenca 6 Other (Specify)

27. Manner of Death: 1 X Neturel 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury et Work? 1 Yes 2 No
28d. Describe how injury occurred
28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. 2 **Medical Examiner:** On the besis of examination and/or Investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signeture end title of certifier: [signature] MD
29c. License number: D19502
29d. Date signed (Month, Dey, Year): December 2, 1998

30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print): ORLANDO B CONANAN M.D. Northwest Hospital Center, Randallstown, Md 21133

State Registrar

31. Date filed (Month, Day, Year): DEC 04 1998
32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 37109

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HILDA W. CUNNINGHAM
2. Date of Death (Month, Day, Yeer): Dec. 2, 1998
3. Time of Death: 1:00 p.m.
4e. Facility Neme (If not institution, give street end number): 1032 Barrymore Drive
4b. City, Town, or Location of Death: Belair
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 213-01-7370
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. lest birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 12, 1908
9. Birthplece (Stete or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Harford
10c. City, Town or Location: Belair
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 1032 Barrymore Drive
10f. Zip Code: 21014
10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Raca - American Indian, Black, White, etc. Specify: White

15. Decadent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Operator
16b. Kind of Business/Industry: Telephone Company

17. Fether's Name (First, Middle, Last): Grover C. Waltz
18. Mother's Neme (First, Middle, Maiden Surname): Katharine F. Grimes

19a. Informent's Name/Relationship (Type, Print): James S. Cunningham (Son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1032 Barrymore Drive, Belair, MD 21014

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from State 4☒ Donetion 5☐ Other (Specify)
20b. Placa of Disposition (Neme of cemetery, cremetory or other pleca): New Cathedral Cemetery
Dete: 12/7/98
20c. Location - City or Town, Stete: Baltimore, Maryland

21. Signeture of Funeral Service Licensee: Richard Trimm
22. Name end Address of Facility: Witzke Funeral Homes, Inc. 1630 Edmondson Avenue, Catonsville, MD 21228

Physician /Medical Examiner

23e. Part I. Enter the diseese, or complications thet caused the death. Do not enter the mode of dying, such es cardiec or respiratory errest, shock, or heart failure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Deeth

Immediate Cause (Final diseese or condition resulting in deeth): e. COPD — Approximete Intervel: >5 yrs

Due to (or es a consequenca of):

Sequentielly list conditions, if any, leading to immediete cause. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in deeth) Lest:
b.
Due to (or es e consequenca of):
c.
Due to (or es e consequenca of):
d.

Part II. **Other elgnificent conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco uee contribute to the cause of death?** 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residenca 6☐ Other (Specify)

27. Manner of Deeth: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Yeer)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, fectory, offica building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Phyeician**: To the best of my knowledge, death occurred et the time, dete end pleca, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner**: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end piece, end due to the ceuse(s) end menner stated.

29b. Signeture end title of certifier: David S Dunn
29c. License number: D32299
29d. Date signed (Month, Dey, Yeer): December 2, 1998

30. Neme end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print): DAVID S DUNN 615 W. MacPhail

State Registrar

31. Date filed (Month, Day, Yeer): DEC 04 1998
32. Registrer's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use in the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37110

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GEORGE COY, JR.

2. Date of Death (Month, Day, Year): NOVEMBER 30, 1998

3. Time of Death: 9:30PM

4a. Facility Name (If not institution, give street and number): 7210 CHAMBERLAIN ROAD

4b. City, Town, or Location of Death: WOODLAWN

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 215-12-3881

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 76 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 09/10/1922

9. Birthplace (State or Foreign Country): VIRGINIA

Usual Residence of Decedent

10a. State: MD

10b. County: BALTIMORE

10c. City, Town or Location: WOODLAWN

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 7210 CHAMBERLAIN ROAD

10f. Zip Code: 21244

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Rece - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 / College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): PLUMBER

16b. Kind of Business/Industry: PLUMBING

17. Father's Name (First, Middle, Last): GEORGE COY, SR.

18. Mother's Name (First, Middle, Maiden Surneme): FRANCES MAYO

19a. Informant's Name/Relationship (Type, Print): DIANE KUNDRATIC/GRAND DAUGHTER

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 7210 CHAMBERLAIN ROAD WOODLAWN, MD 21244

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Neme of cemetery, crematory or other piece): BALTIMORE-WASHINGTON CREMATORY

Date: 12/2/98

20c. Location - City or Town, State: LAUREL, MD

21. Signature of Funeral Service Licensee: Phillip Stark

22. Name and Address of Facility: STERLING-ASHTON-SCHWAB FUNERAL HOME, INC. 736 EDMONDSON AVE. CATONSVILLE, MD 21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heert failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Seizure disorder

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Coronary artery disease.

Due to (or as a consequence of):

c. Anemia

Due to (or as a consequence of):

d. Anxiety

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical exeminer? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner es stated. 2 [ ] **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D30115

29d. Date signed (Month, Dey, Yeer): 12/2/98

30. Name and address of person who completed ceuse of death (Item 23e) (Type, Print): T. OHIOKPEHAI, MD 2600 Liberty Heights Ave Baltimore MD 21215

State Registrar

31. Date filed (Month, Day, Year): DEC 04 1998

32. Registrar's Signature: Jenna G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet tha death certificate be axecuted within 24 hours after death.
To the Funeral Director: After this certificate hes been signed by the attending physician and completaly filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37111

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Debra Ann Carden
2. Dete of Death Month: DEC Dey: 1, Year: 1998
3. Time of Deeth: 5:00 PM
4e. Feciity Neme *(If not institution, give street end number)*: Stella Maris Hospice
4b. City, Town, or Location of Deeth: Towson
4c. County of Death: Baltimore

Funeral Director

5. Sociel Security Number: 220-84-6111
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 35 Yrs.
If Under 1 Year: Months / Deys
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Dey, Year)*: AUG 14, 1963
9. Birthplece *(State or Foreign Country)*: Pennsylvania

Usuel Residence of Decedent

10e. Stete: MD
10b. County: Harford
10c. City, Town or Location: Bel Air
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 2144 Thomas Run Road
10f. Zip Code: 21015
10g. Citizen of Whet Country?: USA
11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indien, Black, White, etc. *Specify:* White
15. Decedent's Educetion *(Specify only highest grede completed)*: Elementery/Secondary (0-12): 12 / College (1-4or 5+):
16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: School Bus Driver
16b. Kind of Business/Industry: Private Bus Co. / Public School Contract
17. Fether's Name *(First, Middle, Last)*: Dean Ellis
18. Mother's Neme *(First, Middle, Maiden Surname)*: Shirley Moon
19a. Informant's Name/Reletionship *(Type, Print)*: David Cecil Carden, Jr. / husband
19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 2144 Thomas Run Road Bel Air, MD 21015
20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removel from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other piece)*: Metro Crematory, Inc.
Dete: 12/3/98
20c. Location - City or Town, Stete: Baltimore, MD
21. Signature of Funeral Service Licensee: George E. MacNabb
22. Neme and Address of Feciity: Cremation Society of Md., Inc. 299 Frederick Road Baltimore, MD 21228

To Be Completed by Funeral Director

DECEMBER 1, 1998 5:00 p.m.
Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DEBRA CARDEN
Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiec or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.
Approximate Intervel Between Onset end Deeth

Immediete Cause (Final diseese or condition resulting in death): e. VAGINAL CANCER
Due to (or es e consequence of):
Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Lest
b. Due to (or es e consequence of):
c. Due to (or es e consequence of):
d.

Pert II. **Other significent conditione** contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. Did tobecco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown
24e. Wes en eutopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? 1☐ Yes 2☐ No
25. Wes cese referred to medical exeminer? 1☐ Yes 2☒ No
28. Piece of Deeth *(Check only one)*: Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* HOSPICE
27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28e. Dete of Injury *(Month, Dey Yeer)*
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Locetion *(Street end Number or Rurel Route Number, City or Town, Stete)*

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as bural-transit

29a. Certifier *(Check only one)*: 1☒ **Certifying Physicien:** To the best of my knowledge, death occurred et the time, date and place, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the besis of examination end/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) end menner stated.
29b. Signature and title of certifier:
29c. Licenae number: 1/15504
29d. Date signed *(Month, Dey, Yeer)*: 12 / 98
30. Neme end eddress of person who completed ceuse of deeth (Item 23a) (Type, Print): DR. EDDIE NAKHUDA, 2300 DULANEY VALLEY ROAD, TIMONIUM, MD 21093

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 04 1998
32. Registrer's Signeture: D. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37112

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): VIRGINIA DAVIS
2. Dete of Deeth: Month 11 Dey 30 Yeer 98
3. Time of Death: 8:30 AM
4e Feciity Name (If not institution, give street end number): Bon Secours
4b. City, Town, or Location of Deeth: Baltiomre City
4c. County of Deeth: N/A

Funeral Director

5. Sociel Security Number: 218-03-1549
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. iest birthday): 80 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 7-14-1918
9. Birthpiece (State or Foreign Country): Virginia

Usuel Residence of Decedent

10a. Stete: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Pasadena
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 124 Maryland Ave.
10f. Zip Code: 21122
10g. Citizen of Whet Country?: United States

11. Meritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Bleck, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12; College (1-4or 5+):
16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home
17. Father's Name (First, Middle, Last): Dennis Karras
18. Mother's Neme (First, Middle, Maiden Surname): Etta Pooley
19e. Informent's Neme/Reletionship (Type, Print): Charles T. Swift / Son
19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code): 2794 Primrose Lane York, P.A. 17402
20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from State 4☐ Donation 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, crematory or other place): Loudon Park Cemetery
Date: 12/02/98
20c. Location - City or Town, Stete: Baltimore MD.
21. Signeture of Funerel Service Licensee: ▶ Dan A. Imbesi
22. Neme and Address of Facility: Ambrose Funeral Home, Inc. 21227 1328 Sulphur Spring Road Arbutus Maryland

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Deeth

Immediate Ceuse (Final disease or condition resulting in death): e. SEPSIS — 24 HOURS

Due to (or es e consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Lest:
b. URINARY TRACT INFECTION — 3 DAYS
Due to (or es e consequence of):
c. ALZHEIMERS DEMENTIA — 10 YEARS
Due to (or as e consequence of):
d.

Pert II. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Pert I.

23b. Did tobecco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☑ No

24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Piece of Deeth (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☑ Nature 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Yeer)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Phyeicien:** To the best of my knowledge, death occurred et the time, dete end piece, end due to the ceuse(s) end menner es stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end place, end due to the cause(s) and menner steted.

29b. Signeture end title of certifier: ▶ Janet V. Moghazeli, MD
29c. License number: D14949
29d. Date signed (Month, Day, Year): 12/1/98

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): JANET V. MOGHAZELI, MD BON SECOURS HOSPITAL BALTIMORE MD 21223

State Registrar

31. Dete filed (Month, Day, Year): DEC 04 1998
32. Registrer's Signeture: ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

6

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 37113

Item:5, per F.H G-766 12/11/98 reb

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month / Day / Year	3. Time of Death
MARIE DEIBEL		DECEMBER 1 1998	10:00 P.M.
4e. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death	
ST. AGNES HEALTHCARE	BALTIMORE	N/A	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-03-~~3285~~ 8646	1☐ M 2☒ F	81 Yrs.			1-28-1917	Maryland

Usual Residence of Decedent

10e. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Arbutus	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1555 Sulphur Spring Road	21227	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8		Packer	Retail Sales

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Thomas Goldhammer	Bessie Talbott

19e. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Marlene Deibel / Daughter	1555 Sulphur Spring Rd. Arbutus, Md. 21227

20e. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Meadowridge Memorial	12/5/98	Dorsey, Maryland

21. Signature of Funeral Service Licensee: Stan A. Lubell

22. Name and Address of Facility: Ambrose Funeral Home of Lansdowne 21227, 2719 Hammonds Ferry Rd. Lansdowne, Md.

Physician ~~Medical~~ Examiner

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. MYOCARDIAL INFARCTION — 96 HOURS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last
b. CORONARY ARTERY DISEASE

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

BRONCHITIS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☑ No	1☐ Yes 2☑ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☑ No	Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
M. Khan, MD MEDICAL RESIDENT	P12593	DECEMBER 1, 1998

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
MOHAMMAD Y. KHAN, M.D. 900 CATON AVENUE, BALTIMORE, MARYLAND 21229

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 04 1998	Geneva G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 37114

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Gerald W. D'Ambrosia
2. Data of Death Month Day Year: November 29, 1998
3. Time of Death: 6:10 PM
4a. Facility Name (If not institution, giva street and number): Mercy Hospice
4b. City, Town, or Location of Death: Baltimore
4c. County of Deeth: N/A

Funeral Director

5. Social Security Number: 073-44-9013
6. Sex: 1 ☒ M 2 ☐ F
7. Age (tn yrs. last birthday): 44 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Year): 03-05-1954
9. Birthplace (State or Foreign Country): Baltimore

Usual Residenca of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore City
10d. Inside City Limits: 1 ☐ Yes 2 ☐ No XX
10e. Street and Number: 501 E. Preston St. Apt 717
10f. Zip Code: 21202
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Nevar Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced XX
12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No XX If Yes, Give Yaar or Datas:
13. Wes Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No X Specify:
14. Race - American Indian, Black, Whita, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12th grade | College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Health Care Provider
16b. Kind of Business/Industry: Private

17. Fathar's Nama (First, Middle, Last): Gerald Palmer
18. Mother's Name (First, Middle, Maiden Sumame): Alma Johnson

19a. Informant's Name/Ralationship (Type, Print): Pamela Asbury/Sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 163-39 130th Ave. Jamaica, NY 11434

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory
Date: 12-01-98
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: William C. Brown Community Funeral Home P.A. 1206 W. North Ave

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on eech line.

Approximate Intervel Between Onset and Death

Immediate Cause (Final disaasa or condition resulting in death): a. Acquired Immunodeficiency Syndrome — Unknown

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that Initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an eutopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were eutopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) STELLA MARIS AT MERCY HOSPICE

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicida 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yas 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as steted. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D 40854
29d. Date signed (Month, Day, Year): November 30, 1998

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): David Riseberg 301 St Paul Pl Baltimore, MD 21202

State Registrar

31. Date filed (Month, Day, Year): DEC 04 1998
32. Registrar's Signature: [signature] B. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

D'AMBROSIA, GERALD

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

98 37115

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DAVID Eaddy

2. Date of Death (Month, Day, Year): November 27, 1998

3. Time of Death: 18 40 PM

4a. Facility Name (If not institution, give street and number): University of Maryland medical System

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 249-38-3478

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 69 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): AUG. 31, 1929

9. Birthplace (State or Foreign Country): S.C.

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 1300 WASHINGTON BLVD. APT. 114

10f. Zip Code: 21230

10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: AFR. AMERICAN

15. Decedent's Education (Specify only highest grede completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 0

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): CEMETERIAN

16b. Kind of Business/Industry: CEMETERY

17. Father's Neme (First, Middle, Last): JOE EADDY

18. Mother's Name (First, Middle, Maiden Sumame): JULIA WILLIAMS

19a. Informant's Name/Relationship (Type, Print): ANN HUBBARD

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 1227 S. CAREY BALTIMORE MD 21230

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other (Specify)

20b. Piece of Disposition (Neme of cemetery, crematory or other piece): MT. ZION CEMETERY

Date: DEC. 4, 1998

20c. Location - City or Town, Stete: BALTO. MD

21. Signature of Funeral Service Licensee: EUGENE N WALKER

22. Name end Address of Facility: ESTEP BROTHERS FUNERAL HOME P.A. 1300 EUTAW PLACE BALTO. MD 21217

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediete Ceuse (Final disease or condition resulting in death)

e. multiOrgan System failure — 4 DAYS

Due to (or es e consequenca of):

b. Septic Shock — 12 DAYS

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest

Due to (or es e consequence of):

c. Ischemic Colitis — 15 DAYS

Due to (or es e consequence of):

d.

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

Cirrhosis of the Liver

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Wes en eutopsy performed? 1 [X] Yes 2 [ ] No

24b. Were eutopsy tindings evaileble prior to completion of ceuse of deeth? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Naturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end place, end due to the ceuse(s) and menner es steted. 2 [ ] **Medical Examiner:** On the besis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: P11411

29d. Date signed (Month, Day, Yeer): 12/1/98

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Jennifer Malossi, MD University of Maryland Medical System, 22 S. Greene St.

State Registrar

31. Date filed (Month, Day, Year): DEC 04 1998

32. Registrer's Signature

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pagas 1 and 2 should be filed within 72 hours after death with tha Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: Tha law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by tha attanding physician and completely filled in by tha funeral director, page 2 should be detached for use as the burial-transit

98-6855-033
DDG
THOMAS ECKROAD
ITEMS: #23 #23 PART I, 27, PER MEO G766 12-9-98 WR.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37116

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Thomas Milburn Eckroad
2. Date of Death (Month, Day, Year): NOVEMBER 29, 1998
3. Time of Death: 2040 PM
4a. Facility Name (If not institution, give street and number): 14720 MT. CALVERT ROAD
4b. City, Town, or Location of Death: UPPER MARLBORO
4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 275 46 0435
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 50 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 27, 1948
9. Birthplace (State or Foreign Country): Ohio

Usual Residence of Decedent

10a. Stete: Maryland
10b. County: Prince George's
10c. City, Town or Location: Upper Marlboro
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 14720 Mt. Calvert Road
10f. Zip Code: 20772
10g. Citizen of Whet Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U.S. Armed Forcas? 1 [ ] Yes 2 [X] No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Raca - American Indien, Black, Whita, atc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12 | College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Professor
16b. Kind of Business/Industry: University of Maryland and Johns Hopkins

17. Fethar's Nema (First, Middle, Last): Wallace Eckroad
18. Mother's Neme (First, Middle, Maiden Surname): Elizabeth Brodt

19a. Informent's Neme/Retetionship (Type, Print): Torgunn Eckroad Wife
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14720 Mt. Calvert Road Upper Marlboro MD. 20772

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremetion 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other placa): Metropolitan Crematory | Dec. 2, 1998
20c. Location - City or Town, Stete: Alexandria Virginia

21. Signature of Funeret Service Licensee: Todd Siller
22. Name end Address of Facility: Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the moda of dying, such es cardiac or respiratory arrest, shock, or heert failure. List only one cause on eech line. (Approximata Intervet Between Onset end Death)

Immediete Ceuse (Final disaese or condition resulting in death): e. DILATED CARDIOMYOPATHY
Due to (or es a consequenca of):
Sequentially list conditions, if any, laeding to immadiate cause. Enter Underlying Cause (Diseese or Injury that initiated evants resulting in deeth) Last:
b. Due to (or as e consequence of):
c. Due to (or es e consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was en eutopsy performed? 1 [✓] Yes 2 [ ] No
24b. Were eutopsy findings eveilable prior to completion ot cause of death? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medicat examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospitel: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner as stated. 2 [X] **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end placa, end due to the ceuse(s) end manner stated.

29b. Signeture end title of certifier: J Pestaner M.D
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): NOVEMBER 30, 1998

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed (Month, Day, Year): DEC 04 1998
32. Registrar's Signatura: Denise G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

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RKD

98-6929-510

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

DAVID FISCHER ITEMS: #23 PART I, 27, 28A-F, 26 PER MED PHY G766 12-7-98 WR.

Certificate of Death

Reg. No. 98 37117

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
David		Fisher, Sr.	NOVEMBER 28, 1998	6:15P.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
1533 E.33rd STREET	BALTIMORE	NA

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219-70-6695	1☒ M 2☐ F	43 Yrs.			10-17-55	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	NA	Baltimore	1☐ Yes 2☐ No XX

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
904 N. Broadway	21205	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10th Grade	NA	Janitorial	Janitorial Service

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Elmer Fisher, Sr.	Ida Mae Thompson

19a. Informent's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Md.
Elmer Fisher,Sr.	1400 E. Madison Street Apt.#1105 Baltimore,

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)	Voshell Mem. Gardens	12-03-98	Dundalk,Md.

21. Signature of Funeral Service Licensee ▶ Debra M Davis

22. Name and Address of Facility Baltimore, Maryland 21202
WM.C.March FH 1101 E. North Avenue

Physician /Medical Examiner

29a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. NARCOTIC INTOXICATION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒ Yes 2☐ No	1☒ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒ Yes 2☐ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☒ Residence 6☒ Other (Specify) SCENE

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☒ Pending investigation 6☒ Could not be determined	Found: 11-28-98	Found: 6:00 p M	1☐ Yes 2☒ No	SUBJECT INGESTED DRUGS

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
FOUND IN HOUSE	1533 E. 33rd. ST. BALTIMORE, MD.

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
XX **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Stephen R Radentz, MD	O.C.M.E.	NOVEMBER 29, 1998

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 4 1998	▶ Jeanne G. [illegible]

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37118

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): RITA FURBY
2. Date of Death (Month, Day, Year): DECEMBER 03, 1998
3. Time of Death: 11:00 PM
4a. Facility Name (If not institution, give street and number): Saint Joseph Medical Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 235-62-0461
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 11/4/08
9. Birthplace (State or Foreign Country): WEST VIRGINIA

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: HILLENDALE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1219 HALSTEAD ROAD
10f. Zip Code: 21234
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th GRADE; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): NELSON SHREVE
18. Mother's Name (First, Middle, Maiden Surname): LUCY SNYDER

19a. Informant's Name/Relationship (Type, Print): MARIE RUOKER DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1219 HALSTEAD ROAD BALTIMORE, MD 21234

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): MINGO CEMETERY | Date: 12/8/98
20c. Location - City or Town, State: MINGO, WV

21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one cause on aach line.

		Approximate Intarval Between Onset end Death
Immediate Cause (Final disease or condition resulting in death)	a. CEREBROVASCULAR ACCIDENT	2 DAYS
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as e consequence of):	
	c.	
	Due to (or es e consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only ona): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Homa 5☐ Rasidence 6☐ Other (Specify)

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Data of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and placa, end due to the ceuse(s) and mennar as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date and placa, end due to the cause(s) and manner stated.

29b. Signeture end title of certifier: Joginder P Mehta, M.D
29c. License number: D41410
29d. Date signed (Month, Day, Year): December 7th, 1998.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOGINDER P. MEHTA, M.D., 7620 YORK ROAD, TOWSON, MARYLAND 21204

State Registrar

31. Dete filed (Month, Day, Year): DEC 14 1998
32. Registrar's Signature: Denise G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pagas 1 and 2 should be filed within 72 hours afar death with the Maryland Department of Haalth and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached by use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 37119

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedant's Nama (First, Middla, Last)			2. Data of Daath Month	Day	Yaar	3. Tima of Death
HELEN	L.	FUNKHOUSER	December	2,	1998	2:50 PM

4a Facility Nama (If not institution, giva street and number)	4b. City, Town, or Location of Daath	4c. County of Death
Gilchrist Center	Towson	BaLTIMORE

Funeral Director

5. Social Security Number	6. Sax	7. Aga (In yrs. last birthday)	If Under 1 Yaar: Months	Days	If Undar 24 Hrs.: Hours	Min.	8. Data of Birth (Month, Day, Yaar)	9. Birthplaca (Stata or Foraign Country)
213-16-0983	1☐ M 2☒ F	Yrs.					June 20, 1916	Md.

Usual Rasidance of Dacedant

10a. Stata	10b. County	10c. City, Town or Location	10d. Insida City Limits
Md.	Baltimore	Towson	1☐ Yas 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizan of What Country?
1 Southerly Court	21204	USA

11. Marital Status	12. Was Dacedant Evar in U.S. Armad Forcas?	13. Was Dacedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.)	14. Raca - Amarican Indian, Black, Whita, atc.
1☐ Navar Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:	1☐ Yas 2☒ No Specify:	Specify: White

15. Decedant's Education (Specify only highast grada complatad)		16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired)	16b. Kind of Businass/Industry
Elementary/Secondary (0-12)	Collaga (1-4or 5+)		
12		Doctor's Assistant	Medical

17. Fathar's Nama (First, Middla, Last)			18. Mothar's Nama (First, Middle, Maiden Surname)		
G.	Elmer	Harsh	Mary	E.	Draper

19a. Informant's Name/Ralationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code)
Ralph A. Funkhouser/husband	1 Southerly Ct. Towson, Md.21204

20a. Mathod of Disposition	20b. Placa of Disposition (Nama of camatary, cramatory or othar placa)	Data	20c. Location - City or Town, Stata
1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Spacify)	St. John's Lutheran	12/5/98	Parkville, Md.

21. Signatura of Funaral Servica Licansaa

22. Nama and Addrass of Facility
Ruck Towson Funeral Home, Inc.
1050 York Rd. Towson, Md. 21204

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that causad tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on aach lina.

		Approximata Interval Batween Onsat and Death
Immediata Causa (Final disaasa or condition resulting in death)	a. Colon cancer	9 months
	Dua to (or as a consaquance of):	
Sequantially list conditions, if any, laading to immadiata ceuse. Enter Undarlying Causa (Disaasa or injury that initiated avants rasulting in daath) Last	b.	
	Dua to (or as a consaquance of):	
	c.	
	Dua to (or as a consequance of):	
	d.	

Part II. **Othar significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.

23b. Did tobacco usa contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Wara autopsy findings available prior to completion of ceusa of daath?
1☐ Yas 2☒ No	1☐ Yas 2☐ No

25. Was casa rafarrad to medical examinar?	26. Placa of Daath (Chack only ona)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA	Othar: 4☐ Nursing Homa 5☐ Rasidance 6☒ Othar (Specify) Hospice

27. Mannar of Daath	28a. Data of Injury (Month, Day Yaar)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Panding invastigation 6☐ Could not ba datarmined		M	1☐ Yas 2☐ No	
	28a. Placa of Injury - At home, farm, street, factory, offica building, atc. (Specify)			28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To tha best of my knowledga, daath occurrad at the time, date and place, and due to the ceuse(s) and mannar as stated.
2☐ **Medical Examiner:** On tha basis of examination and/or invastigation, in my opinion, death occurrad at the tima, data and place, and dua to tha causa(s) and mannar stated.

29b. Signature and title of certifier	29c. Licansa number	29d. Data signed (Month, Day, Year)
W. Anthony Riley, MD	D25205	December 2, 1998

30. Nama and addrass of person who compliatad ceuse of daath (Itam 23a) (Type, Print)
W.A. Riley GBMC 6701 N. Charles St. Balto. Md 21204

State Registrar

31. Data filed (Month, Day, Yaar)	32. Registrar's Signatura
DEC 04 1998	Geneva G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Helen Funkhauser 12-2-98 230pm

10 pgs

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 37120

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WILLIAM ALBERT FISHPAW SR

2. Data of Deeth: Month DECEMBER Day 2, Year 1998

3. Time of Death: 1:37 PM

4a Facility Name (If not institution, give street and number): Saint Joseph Medical Center

4b. City, Town, or Location of Death: Towson

4c. County of Deeth: Baltimore

Funeral Director

5. Social Sacurity Number: 217-26-7362

6. Sex: 1☐ M 2☐ F — X

7. Age (In yrs. last birthday): 81 Yrs.

If Under 1 Yaar: Months / Deys

If Undar 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Dey, Year): March 21,1917

9. Birthplaca (Stata or Foreign Country): Maryland

Usual Residence of Decedent

10e. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Cockeysville

10d. Inside City Limits: 1☐ Yas 2☒ No

10e. Street end Number: 202 Sherwood Road

10f. Zip Code: 21030

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedant Evar in U,S. Armad Forcas? 1☒ Yes 2☐ No — If Yes, Give Year or Detes: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Rece - Amarican Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementery/Secondary (0-12): 12 yrs.

College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Machinist

16b. Kind of Business/Industry: Baltimore Broom Co.

17. Fethar's Name (First, Middle, Last): Malcolm Fishpaw

18. Mother's Nama (First, Middle, Maiden Sumame): Mary M. Parks

19a. Informant's Name/Reletionship (Type, Print): Mrs. Dorothy E. Fishpaw/Wife

19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code): 202 Sherwood Road Cockeysville, Md. 21030

20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Othar (Spacify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Grace Methodist Cemetery

Date: 12/5/98

20c. Location - City or Town, State: Chestnut Ridge, Md.

21. Signature of Funeral Service Licensee: [signature]

22. Name end Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Road Towson,Md.21204

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onsat and Death

Immediate Ceuse (Final disease or condition resulting in death): a. CEREBRAL THROMBOSIS — MONTHS

Due to (or es e consequence of):

Sequantially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated avants resulting in death) Last

b. Due to (or as a consequanca of):

c. Due to (or es e consequence of):

d.

Part II. Other significant conditions contributing to deeth but not resulting in tha undarlying cause given in Part I.: ALZHEIMER'S DISEASE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performed? 1☐ Yas 2☒ No

24b. Were eutopsy findings eveilable prior to completion of cause of death? 1☐ Yes 2☒ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

26. Piece of Death (Check only one): Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other (Specify)

27. Mannar of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not ba determined

28a. Deta of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end pleca, end due to the ceuse(s) end menner stated.

29b. Signature end title of certifier: Beatriz P. Dizon, M.D.

29c. License number: D16492

29d. Date signed (Month, Dey, Year): December 2, 1998

30. Name end address of person who completed cause of death (Item 23e) (Type, Print): BEATRIZ P. DIZON, M.D., 7620 YORK ROAD, TOWSON, M.D. 21204

State Registrar

31. Date filed (Month, Day, Year): DEC 04 1998

32. Registrar's Signetura: Geneva G. Sparks

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37121

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Dete of Deeth Month / Day / Year	3. Time of Deeth
JOHN	A.	FRANCIS	Nov 30 1998	13:10

4e Feciility Neme (If not institution, give street end number)	4b. City, Town, or Location of Death	4c. County of Deeth
GOOD SAMARITAN HOSPITAL	BALTIMORE	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Deys	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Dey, Yeer)	9. Birthplace (State or Foreign Country)
216-30-5532	1☒ M 2☐ F	67 Yrs.			Feb. 27, 1931	Maryland

Usuel Residenca of Decedent

10e. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Harford	Abingdon	1☐ Yes 2☒ No

10e. Street end Number	10f. Zip Code	10g. Citizen of Whet Country?
3802 Hebron Terrace	21009	U.S.A.

11. Mariiel Stetus	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.)	14. Race - American Indien, Bleck, White, etc.
1☐ Never Merried 2☒ Married 3☐ Widowed 4☐ Divorced	1☒ Yes 2☐ No If Yes, Give Year or Detes: 1951-55	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondery (0-12)	College (1-4or 5+)		
11th grade		Service dispatcher	Car Dealership

17. Fether's Name (First, Middle, Lest)	18. Mother's Name (First, Middle, Maiden Sumame)
Robert N. Francis	Christine M. Muir

19a. Informent's Name/Relationship (Type, Print)	19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)
Margaret N. Francis (Wife)	3802 Hebron Terrace, Abingdon, MD. 21009

20e. Method of Disposition	20b. Piece of Disposition (Name of cemetery, cremetory or other place)	Date	20c. Location - City or Town, Stete
1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☒ Other (Specify) Entombment	Woodlawn Cemetery	12/4/98	Baltimore, Maryland

21. Signeture of Funeral Servica Licensee	22. Name and Address of Feciility
▶ Robert J. Rock	Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, MD. 21014

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert failure. List only one cause on each line.

Approximete Interval Between Onset end Deeth

Immediate Ceuse (Finel disease or condition resulting in death) e. PNEUMONIA

Due to (or es e consequenca of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting in deeth) Lest

b. Due to (or es e consequence of):

c. Due to (or as e consequenca of):

d.

Part II. **Other elgnificant conditione** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was en eutopsy performed?	24b. Were eutopsy findings eveileble prior to completion of cause of death?
1☐ Yes 2☑ No	1☐ Yes 2☐ No

25. Wes case referred to medical examiner?	26. Piece of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other (Specify)

27. Menner of Deeth	28e. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)			28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end pleca, end due to the ceuse(s) end menner es steted.
2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, dete end place, end due to the ceuse(s) and manner stated.

29b. Signeture end title of certifier	29c. License number	29d. Date signed (Month, Dey, Yeer)
▶ Mark Cain MD	P-11403	NOVEMBER 30, 1998

30. Neme end eddress of person who completed cause of death (Item 23a) (Type, Print)
MANAKO KURODA MD GOOD SAMARITAN HOSPITAL 5601 LOCH RAVEN BLVD BALTIMORE MD 21239

State Registrar

31. Dete filed (Month, Day, Yeer)	32. Registrer's Signature
DEC 04 1998	Donna G. Sparks

8+1 PEB

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 37122

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Neme *(First, Middla, Last)*: AGNES FRISCH

2. Date of Death Month Day Yeer: NOVEMBER 30, 1998

3. Time of Death: 7:10PM

4e. Facility Name *(If not institution, give street end number)*: 10 EUGENA AVE.

4b. City, Town, or Location of Deeth: GLEN BURNIE

4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 213-03-9552

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 04/30/1911

9. Birthplece *(Stata or Foraign Country)*: MARYLAND

Usuel Residence of Decedent

10a. State: MD

10b. County: ANNE ARUNDEL

10c. City, Town or Locetion: GLEN BURNIE

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 10 EUGENA AVE.

10f. Zip Code: 21061

10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highast grade complatad)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupetion *(Giva kind of work dona during most of working lifa. DO NOT use retirad)*: SALES

16b. Kind of Business/Industry: COSMETIC

17. Father's Name *(First, Middle, Last)*: JOSEPH MULLIGAN

18. Mother's Name *(First, Middle, Maidan Surnama)*: LILLIAN (UNKNOWN)

19e. Informant's Name/Relationship *(Type, Print)*: JACK D. JOHNS/FRIEND

19b. Meiling Address *(Street and Number or Rural Route Numbar, City or Town, State, Zip Code)*: 10 EUGENA AVE. GLEN BURNIE, MD 21061

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Place of Disposition *(Nama of cematary, crematory or othar place)*: BALTIMORE CEMETERY | Date: 12/3/98

20c. Location - City or Town, State: BALTIMORE, MD

21. Signature of Funeral Service Licensee ▶

22. Name and Address of Facility: STERLING-ASHTON-SCHWAB FUNERAL HOME, INC. 736 EDMONDSON AVE. CATONSVILLE, MD. 21228

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximete Intervel Between Onset and Death
Immediate Ceuse (Final disease or condition resulting in death) a.	VENTRICULAR ARRHYTHMIA	MINUTES
Due to (or as a consequence of): b.	HYPERKALEMIA	MINUTES
Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last — Due to (or as e consequence of): c.	END STAGE RENAL DISEASE	YEARS
Due to (or es a consequence of): d.	HIGH BLOOD PRESSURE	YEARS

Part II. **Other significant conditiona** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☑ No

24b. Were eutopsy findings eveileble prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Deeth *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA | Other: 4☐ Nursing Home 5☑ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☑ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Yaar)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Straat and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Phyaician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end menner es steted. 2☐ **Medical Exeminer:** On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) end manner stated.

29b. Signeture and title of certifier ▶ Bernard M Lander

29c. License number: D29296

29d. Date signed *(Month, Day, Year)*: DECEMBER 1 1998

30. Neme and eddress of person who completed ceuse of deeth (Item 23e) (Type, Print): 901 E. FORT AVE BALTIMORE MARYLAND 21230

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 04 1998

32. Registrer's Signature ▶ Geneva B. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other then "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item:16a per F.H G-766 12/4/98 reb

Certificate of Death

Reg. No. 98 37123

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Theodore George Hart Jr.	December 3, 1998	7:42 a.m.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
3218 Harford Road	Baltimore City	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215-12-9909	1☒ M 2☐ F	78 Yrs.			Dec. 28 1919	Baltimore, Md.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	N/A	Baltimore City	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3218 Harford Road	21218	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)	~~Relator~~ Realtor	Real Estate
12			

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Theodore G. Hart Sr.	Marie E. Vogelsang

19a. Informent's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Kathy M. Hart Daughter	1907 Forest Court Timonium, Maryland 21093

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Hilltop Service Corp.	12/4/98	Towson, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Timothy S. Hall	Leonard J. Ruck, Inc. 5305 Harford Rd. Baltimore, Maryland 21214

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. dementia	2 years
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Adams MD	D32783	12/3/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Joseph Adams MD 7401 Osler Drive Towson Md 21204

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 04 1998	▶ Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37124

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Elbert R Hardin

2. Date of Death (Month, Day, Year): November 21, 1998

3. Time of Death: 3:42 PM

4a. Facility Name (If not institution, give street and number): 211 Courtland Ave.

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 230-28-6918

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 72 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept. 17, 1926

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: MD.

10b. County: Baltimore

10c. City, Town or Location: Towson

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 211 Courtland Ave.

10f. Zip Code: 21204

10g. Citizen of What Country? USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 0 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Carpenter

16b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): Stuart Harden

18. Mother's Name (First, Middle, Maiden Surname): Anne Medly

19a. Informant's Name/Relationship (Type, Print): Mr. Paul Hanley/ Attorney

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 206 Washington Ave. Towson, MD. 21204

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): Prospect Hill Cemetery

Date: 12/2/98

20c. Location - City or Town, State: Towson, MD.

21. Signature of Funeral Service Licensee: ▶ K A P S

22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, MD. 21204

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Essential Hypertension

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Charles F O'Donnell MD

29c. License number: D-09383

29d. Date signed (Month, Day, Year): November 23, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Charles F. O'Donnell MD Hamlet Hill Rd Baltimore MD 21210

State Registrar

31. Date filed (Month, Day, Year): DEC 04 1998

32. Registrar's Signature: ▶ Deputy D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

4+1

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37125

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): FRANCES M. HARRIS

2. Date of Death — Month: December Day: 3 Year: 1998

3. Time of Death: 04:12

4a. Facility Name (If not institution, give street and number): ST AGNES HEALTHCARE

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-14-6798

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 74 Yrs.

If Under 1 Year — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Date of Birth (Month, Day, Year): 1/27/24

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 3503 GELSTON AVE

10f. Zip Code: 21229

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): -12-

College (1-4or 5+): -2-

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): DIETICIAN

16b. Kind of Business/Industry: MEDICINE

17. Father's Name (First, Middle, Last): CHARLES RODGORS

18. Mother's Name (First, Middle, Maiden Surname): FRANCES MILLER

19a. Informant's Name/Relationship (Type, Print): ELAINE JACKSON(DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5629 GOVANE AVE BALTIMORE, MD 21212

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): MD. NATIONAL MEM. PARK

Date: 12/7/98

20c. Location - City or Town, State: LAUREL, MARYLAND

21. Signature of Funeral Service Licensee: Loretta Hecht CFSP

22. Name and Address of Facility: E.L. PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MD 21217

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Myocardial Infarction	24 hours
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.	Cerebral Anoxia	24 hours
Due to (or as a consequence of):		
c.	Atrial Fibrillation	24 hours
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) — Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John P. O'Connor

29c. License number: P11700

29d. Date signed (Month, Day, Year): December 3, 1998

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): John P. O'Connor 900 Caton Avenue Baltimore MD 21229

State Registrar

31. Date filed (Month, Day, Year): DEC 04 1998

32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

NAME Harris, Frances

RB 5

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37126

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: RALPH HUDSON
2. Date of Death: Month 11 Day 30 Year 1998
3. Time of Death: 12:15 P.m
4a. Facility Name *(If not institution, give street and number)*: 2 Mt Batten Court
4b. City, Town, or Location of Death: Randallstown
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 215-28-3964
6. Sex: 1 ☒ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 65 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 2-11-1933
9. Birthplace *(State or Foreign Country)*: Md

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Md
10b. County: Baltimore
10c. City, Town or Location: Randallstown
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 2 Mt Batten Court
10f. Zip Code: 21207
10g. Citizen of Whet Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education *(Specify only highest grede completed)*: Elementary/Secondary (0-12): 12th grade; College (1-4or 5+): 4 years
16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Police Officer
16b. Kind of Business/Industry: Baltimore City Police

17. Father's Name *(First, Middle, Last)*: Ralph W. Hudson, Sr
18. Mother's Name *(First, Middle, Maiden Surname)*: Ethel Washington

19a. Informant's Name/Relationship *(Type, Print)*: Esther Hudson - wife
19b. Mailing Address *(Street and Number or Rurel Route Number, City or Town, State, Zip Code)*: 2 Mt Batten Ct Apt 203 Randallstown, Md 21207

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Neme of cemetery, crematory or other place)*: Garrison Forest Veteran — Date: 12-7-98
20c. Location - City or Town, Stete: Owings Mills, Md

21. Signature of Funeral Service Licensee: Gabrielle Cook
22. Name end Address of Facility: March F.H. West 4300 Wabash Avenue Balto, Md 21215

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line. — Approximate Intervel Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. ACUTE MYOCARDIAL INFARCTION
Due to (or as a consequence of):
b. ATRIAL FIBRILATION

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last
Due to (or as e consequence of):
c. HYPERTENSIVE HEART DISEASE
Due to (or as e consequence of):
d. ATHEROSCLEROTIC HEART DISEASE

Part II. **Other significent conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.: gross Obesity

23b. Did tobecco use contribute to the ceuse of deeth? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Wes an eutopsy performed? 1 ☐ Yes 2 ☐ No
24b. Were eutopsy findings available prior to completion of cause of deeth? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical exeminer? 1 ☐ Yes 2 ☑ No
26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other *(Specify)*
27. Manner of Deeth: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury et Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☑ **Certifying Physicien**: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) end menner es stated. 2 ☐ **Medical Examiner**: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end piece, end due to the ceuse(s) and manner stated.
29b. Signeture and title of certifier: [signature]
29c. License number: D15300
29d. Date signed *(Month, Day, Yeer)*: 12/01/98

30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print): SWADESH K BHATIANI, 6609 Reisterstown Rd. BALT, MD 21215

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 04 1998
32. Registrer's Signature: [signature] G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

6/1 PETS

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37127

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): RUTH HASKINS
2. Date of Death (Month, Day, Year): December 3, 1998
3. Time of Death: 12:14p
4e. Facility Name (If not institution, give street end number): The Johns Hopkins Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-14-9335
6. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 5-23-15
9. Birthplace (State or Foreign Country): NC

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street end Number: 1318 N. KENWOOD AVENUE
10f. Zip Code: 21213
10g. Citizen of Whet Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☑ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:
14. Race - American Indien, Bleck, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 8 TH GRADE | College (1-4or 5+): N/A
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): DOMESTIC
16b. Kind of Business/Industry: HOME

17. Father's Neme (First, Middle, Last): UNKNOWN
18. Mother's Name (First, Middle, Maiden Surneme): ELLA BROWN

19a. Informent's Name/Relationship (Type, Print): JULIE HASKINS-TURNER / DAUGHTER
19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code): 4605 HORIZON CIR., BALTO. MD 21208

20a. Methed of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removel from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, crematory or other place): KING MEMORIAL PARK | Date: 12-8-98
20c. Location - City or Town, State: RANDALLSTOWN, MD

21. Signature of Funeral Service Licensee: Vaughn C Greene
22. Name and Address of Facility: VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL PIKE, BALTO. MD. 21229

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heart failure. List only one ceuse on eech line. (Approximete Intervel Between Onset end Death)

Immediate Ceuse (Final disease or condition resulting in death)
e. GASTROINTESTINAL BLEEDING — 2 DAYS
Due to (or es e consequence of):
b. GASTRIC CARCINOMA
Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last
Due to (or as e consequence of):
c.
Due to (or as e consequence of):
d.

Pert II. **Other eignificent conditions** contributing to deeth but not resulting in the underlying cause given in Part I.
EMPHYSEMA
CONGESTIVE HEART FAILURE

23b. Did tobecco use contribute to the ceuee of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Plece of Deeth (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Phyeicien:** To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) and manner stated.
29b. Signeture end title of certifier: [signature]
29c. License number: RES-000
29d. Date signed (Month, Dey, Year): DECEMBER 3, 1998
30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print): JAMES M. SIZEMORE JR JOHNS HOPKINS HOSPITAL NO TOWER BALTIMORE, MARYLAND 21287

State Registrar

31. Date filed (Month, Day, Year): DEC 04 1998
32. Registrar's Signature: [signature]

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Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

14

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37128

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: THERESA HAWKINS
2. Data of Daeth Month Day Yaar: NOVEMBER 25, 1998
3. Tima of Death: 5:37 PM
4e Facility Name *(If not institution, give street and number)*: Saint Joseph Medical Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 218-09-9229
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 82 Yrs.
If Under 1 Yaar: Months / Deys
If Undar 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Dey, Year)*: June 10, 1916
9. Birthplace *(State or Foreign Country)*: S.C.

Usual Residence of Decedent

10a. State: Md.
10b. County: n/a
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1004 N. Augusta Avenue
10f. Zip Code: 21229
10g. Citizen of Whet Country?: USA

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yas 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12): 12th Grade; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Postal Worker
16b. Kind of Business/Industry: US Postal Service

17. Father's Name *(First, Middle, Last)*: Rufus Holloms
18. Mother's Name *(First, Middle, Meiden Surneme)*: Texas Ann Sample

19a. Informent's Name/Relationship *(Type, Print)*: Paula V. Hawkins Daughter-In-Law
19b. Mailing Address *(Street and Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 1004 N. Augusta Avenue Baltimore, Md. 21229

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Place of Disposition *(Neme of cemetary, crametory or other piece)*: Garrison Forest Veterans
Date: Dec. 4
20c. Location - City or Town, State: Owings Mills, Md.

21. Signature of Funeral Sarvice Licensaa: Herbert E. Nutter
22. Name and Address of Facility: Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216

Physician /Medical Examiner

23a. Pert1. Enter the diseasa, or complications that caused the death. Do not enter tha moda of dying, such es cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line.

Approximata Interval Batween Onset and Death

Immediate Causa (Finel disease or condition resulting in deeth): a. ACUTE MYOCARDIAL INFARCTION — 1 DAY

Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last

b. Due to (or as e consequence of):

c. Dua to (or as a consaquence of):

d.

Pert II. **Othar significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the causa of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Piece of Deeth *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end piece, end due to the cause(s) end manner es stated. 2☐ **Medical Examiner:** On the basis of examination end/or Investigation, in my opinion, death occurrad at the time, dete end place, and due to tha cause(s) end manner stated.

29b. Signature and title of certifier
29c. Licanse number: D30263
29d. Dete signed *(Month, Day, Year)*: 11-26-98

30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print): FRANCIS KHOO, M.D., 7620 YORK ROAD, TOWSON, MARYLAND 21204

State Registrar

31. Date filed *(Month, Dey, Year)*: DEC 04 1998
32. Registrar's Signatura: Geneva B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylend Depertment of Health end Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37129

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: ALBERT CARL HANSEN
2. Dete of Deeth — Month / Day / Year: NOVEMBEL 29, 1998
3. Time of Death: 1150
4a. Facility Neme *(If not institution, give street and number)*: ST. AGNES HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Sociel Security Number: 228-18-0909
6. Sex: [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 76 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 04/09/1922
9. Birthplace *(State or Foreign Country)*: NEW YORK

Usuel Residence of Decedent

10e. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: CATONSVILLE
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Numbar: 426 WESTSIDE BLVD.
10f. Zip Code: 21228
10g. Citizen of Whet Country?: U.S.A.

11. Maritel Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Rece - American Indlan, Bleck, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)* — Elamantary/Secondary (0-12): 12 — Collega (1-4or 5+):
16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: PRINTER
16b. Kind of Businass/Industry: SELF-EMPLOYED

17. Father's Name *(First, Middle, Last)*: MARTIN HILMAR
18. Mother's Name *(First, Middle, Maiden Surname)*: ELLA-PETREA KJAERGAARD

19a. Informent's Name/Relationship *(Type, Print)*: GLORIA C. HANSEN/WIFE
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 426 WESTSIDE BLVD. CATONSVILLE, MD 21228

20e. Mathod of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Ramoval from State 4 [ ] Donetion 5 [ ] Other *(Specify)*
20b. Piece of Disposition *(Name of cemetery, crematory or other place)*: CROWNSVILLE VETERAN CEM.
Dete: 12/3/98
20c. Location - City or Town, Stete: CROWNSVILLE, MD

21. Signature of Funerel Servica Licensee: Phillip Stark
22. Name end Address of Facility: STERLING ASHTON-SCHWAB FUNERAL HOME, INC. 736 EDMONDSON AVE. CATONSVILLE, MD 21228

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complicetions that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Intervel Between Onset and Deeth

Immediate Cause (Final disease or condition resulting in daath): a. Acute Respiratory Failure
Due to (or es e consequence of): b. Advanced Pulmonary Fibrosis — 7 y.
Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Causa (Disaese or Injury that initiated events resulting in death) Lest:
Due to (or as a consequence of): c.
Due to (or as a consequence of): d.

Pert II. **Other significant conditions** contributing to daath but not resulting in tha underlying cause given in Pert I.: Pneumonia - Coronary Artery Disease -

23b. Did tobacco uee contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24e. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No
24b. Wara autopsy findings available prior to completion of cause of death? 1 [ ] Yas 2 [ ] No

25. Wes case referred to medical exeminer? 1 [ ] Yas 2 [X] No
26. Plece of Death *(Check only ona)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Deeth: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Dete of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Dascribe how injury occurrad
28e. Placa of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledga, death occurred et the tima, data and place, and dua to tha cause(s) end menner as steted. 2 [ ] **Medical Examiner**: On tha basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, data end place, end due to the cause(s) and mennar stated.

29b. Signature end title of certifier: Alejandro Megia MD
29c. License number: D 08780
29d. Date signed *(Month, Day, Year)*: Nov 29-98

30. Nema and address of person who completed cause of deeth (Item 23e) (Type, Print): ALEJANDRO MEJIA MD 1405 Frederick Rd Baltimore Md 21228

State Registrar

31. Dete filed *(Month, Day, Year)*: DEC 04 1998
32. Registrar's Signeture: Donna G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020
Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Meryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours efter death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

NAME HANSEN, ALBERT C.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37130

Physician /Medical Examiner

1. Decedent's Nema *(First, Middla, Last)*: Nora C. Halay

2. Date of Death — Month: November Day: 20 Yaar: 1998

3. Tima of Daath: 3 47 Am

4a. Facility Nama *(If not institution, giva street and number)*: Fallston General Hospital

4b. City, Town, or Location of Deeth: Fallston

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 110-05-2017

6. Sex: 1☐ M 2☒ F

7. Aga *(In yrs. last birthday)*: 86 Yrs.

If Under 1 Year — Months: Deys: If Under 24 Hrs. — Hours: Min.:

8. Data of Birth *(Month, Day, Yaar)*: July 19, 1912

9. Birthplace *(Stata or Foraign Country)*: Yonkers, New York

Usual Rasidance ot Dacedant

10a. Stata: New York

10b. County: Westchester

10c. City, Town or Location: Yonkers

10d. Insida City Limits: 1☒ Yas 2☐ No

10a. Street and Number: 50 Riverdale Avenue 6F

10f. Zip Coda: 10701

10g. Citizan ot What Country?: USA

11. Marital Status: 1☐ Navar Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forcas? 1☐ Yas 2☒ No — If Yas, Give Yaar or Dates:

13. Was Decadant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 1☐ Yas 2☒ No Specify:

14. Race - American Indian, Black, Whita, atc. Specify: White

15. Decedant's Education *(Specify only highast grada completed)* — Elementary/Secondary (0-12): 12 — College (1-4or 5+): N/A

16a. Decedent's Usual Occupetion *(Giva kind of work done during most of working lifa. DO NOT usa retired)*: Secretary

16b. Kind ot Business/Industry: Y.W.C.A.

17. Fethar's Nama *(First, Middla, Last)*: William Conlan

18. Mothar's Nama *(First, Middle, Maiden Surname)*: Catherine Unknown

19a. Informant's Name/Ralationship *(Type, Print)*: Patricia Nevin (Daughter)

19b. Meiling Addrass *(Straat end Number or Rural Routa Number, City or Town, Steta, Zip Coda)*: 403 Woodridge Court Fallston, Maryland 21047

20a. Method ot Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Plece ot Disposition *(Nama of cematary, cramatory or othar place)*: St. Mary Cemetery Data: November 23, 1998

20c. Location - City or Town, Stata: Yonkers, New York

21. Signatura of Funeral Servica Licensaa: Heather Lassahn Chojnacki

22. Nama and Addrass of Facility: E.F. Lassahn Funeral Home, P.A. 11750 Belair Road Kingsville, Maryland 21087-1351

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complications that caused the death. Do not antar tha moda of dying, such as cardiac or respiratory errest, shock, or haart failure. List only ona causa on each lina.

Approximata Interval Batwaen Onsat and Death

Immedieta Causa (Final disaasa or condition resulting in death): e. Acute Respiratory Distress Syndrome — 12 hours

Dua to (or as a consequence of):

Sequantially list conditions, if any, leading to immadiata causa. Entar Underlying Causa (Disaasa or injury that initieted avants resulting in deeth) Last:

b.

Dua to (or as e consequance ot):

c.

Dua to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Severe Arteriosclerotic Heart Disease; Diabetes Mellitus - Severe; Coronary Heart Disease

23b. Did tobacco usa contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performad? 1☐ Yas 2☒ No

24b. Wara autopsy findings aveilable prior to completion ot causa ot deeth? 1☐ Yas 2☐ No

25. Was casa referred to medical examiner? 1☐ Yas 2☒ No

26. Placa ot Daath *(Check only ona)*: Hospital: 1☒ Inpatiant 2☐ ER/Outpatient 3☐ DOA — Othar: 4☐ Nursing Homa 5☐ Rasidance 6☐ Othar *(Specify)*

27. Manner ot Deeth: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be datarmined

28a. Data ot Injury *(Month, Day Yaar)*

28b. Time ot Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28e. Place of Injury - At homa, farm, straet, factory, office building, atc. *(Specify)*

28f. Location *(Straat and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifiar *(Check only one)*: 1☒ **Certifying Phyaician:** To tha best of my knowledga, daath occurred at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. 2☐ **Madical Examiner:** On tha basis of examination and/or invastigation, in my opinion, daath occurred at tha tima, data and placa, and dua to the cause(s) and mennar stated.

29b. Signatura and title of certifiar: Willard P. Amass

29c. License number: D07354

29d. Data signed *(Month, Day, Yaar)*: Nov/21/1998

30. Nama and addrass of parson who completed causa of daath (Item 23a) (Type, Print): Willard P. Amass 2383 Belair Rd Fallston, MD 21047

State Registrar

31. Data filed *(Month, Day, Yaar)*: DEC 04 1998

32. Registrer's Signatura: Jennie G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use at the burial-transit

Halay, Nora

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DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37131

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary G. Johnson
2. Date of Death (Month, Day, Year): November 29, 1998
3. Time of Death: 9:45 PM
4a. Facility Name (If not institution, give street and number): Genesis Heritage Eldercare Meridian
4b. City, Town, or Location of Death: Dundalk
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 217-36-2803
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 4, 1916
9. Birthplace (State or Foreign Country): N. Carolina

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Eastwood
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7022 Gough Street
10f. Zip Code: 21224
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 2 Years
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Nurse
16b. Kind of Business/Industry: Health Care

17. Father's Name (First, Middle, Last): James Lucas
18. Mother's Name (First, Middle, Maiden Surname): Birtie Rosa Ray

19a. Informant's Name/Relationship (Type, Print): William S. Johnson/Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12612 Palomar St. Garden Grove, CA 92645

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Oak Lawn Cemetery | Date: 12/3/1998
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee
22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. ACUTE RESPIRATORY FAILURE	1 DAY
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. ARTERIOSCLEROTIC HEART DISEASE	YEARS
Due to (or as a consequence of):		
	c.	
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: DEGENERATIVE JOINT DISEASE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: B. C. Veneracion Jr MD PA
29c. License number: D 13664
29d. Date signed (Month, Day, Year): Nov 30, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): B.C. VENERACION JR M.D. PA. 1576 MERRITT BLVD, BALTO. MD 21222

State Registrar

31. Date filed (Month, Day, Year): DEC 04 1998
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37132

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Dete of Deeth Month / Dey / Yeer	3. Time of Death
WESLEY S. JONES	DECEMBER 2, 1998	5:45pm

4e Fecility Neme (If not institution, give street end number)	4b. City, Town, or Location of Deeth	4c. County of Deeth
2816 Woodbrook Avenue (res.)	Baltimore	N/A

Funeral Director

5. Sociel Security Number	6. Sex	7. Age (In yrs. lest birthdey)	If Under 1 Year: Months / Deys	If Under 24 Hrs.: Hours / Min.	8. Dete of Birth (Month, Dey, Yeer)	9. Birthplece (Stete or Foreign Country)
218-56-2265	1☒ M 2☐ F	45 Yrs.			06/25/1953	Maryland

Usuel Residence of Decedent

10e. Stete	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	N/A	BALTIMORE	1☒ Yes 2☐ No

10e. Street end Number	10f. Zip Code	10g. Citizen of Whet Country?
2816 Woodbrook Avenue	21217	U.S.A.

11. Meritel Stetus	12. Wes Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.)	14. Race - American Indien, Bleck, White, etc.
1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorcad	1☐ Yes 2☒ No If Yes, Give Yeer or Dates:	1☐ Yes 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grede completed)		16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondary (0-12)	College (1-4or 5+)		
12th		Janitor	Boys Latin School

17. Fether's Neme (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surneme)
Charles S. Jones, Sr.	Caroline M. Jones

19a. Informent's Name/Relationship (Type, Print)	19b. Melling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)
Jenell Jiggetts	531 S. Caton Avenue, Balto., MD 21229

20a. Method of Disposition	20b. Place of Disposition (Neme of cemetery, cremetory or other piece)	Date	20c. Location - City or Town, Stete
1☒ Burial 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)	King Memorial Park	12/5/98	Randallstown, MD

21. Signature of Funerel Service Licensee	22. Neme end Address of Fecility
▶ Willie E. Howell	Willie E. Howell, Jr. LEROY O. DYETT & SON FUNERAL HOME, P.A. 4600 LIBERTY HEIGHTS AVE., BALTO., MD 21207

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on eech line.

Approximate Intervel Between Onset end Deeth

Immediate Ceuse (Finel disease or condition resulting in death)
e. METASTATIC ADENOCARCINOMA

Due to (or es e consequenca of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest

b. _____

Due to (or es e consequence of):

c. _____

Due to (or es e consequence of):

d. _____

Pert II. **Other eignificant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cauee of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed?	24b. Were eutopsy findings eveilable prior to completion of cause of deeth?
1☐ Yes 2☑ No	1☐ Yes 2☑ No

25. Wes case referred to medical examiner?	26. Piece of Death (Check only one)	
1☐ Yes 2☑ No	Hospital: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA	Other: 4☐ Nursing Home 5☑ Residenca 6☐ Other (Specify)

27. Menner of Deeth	28e. Date of Injury (Month, Dey Yeer)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end piece, end due to the ceuse(s) end menner es steted.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end piece, end due to the ceuse(s) end menner steted.

29b. Signature end title of certifier	29c. License number	29d. Date signed (Month, Dey, Yeer)
▶ Martin R. Linker MD	D39858	December 2, 1998

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)
MARTIN R. LINKER, MD MARYLAND GENERAL HOSPITAL, BALTIMORE, MD 21201

State Registrar

31. Dete filed (Month, Dey, Yeer)	32. Registrer's Signeture
DEC 04 1998	▶ Genine B. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health end Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funerel director, page 2 should be detached and kept for the burial-transit

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RKD

98-6948-027

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

98-07133

KEVIN

State of Maryland / Department of Health and Mental Hygiene

JONES ITEM: #10B PER F.HHG766 12-4-98 WR.

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Data of Death Month / Dey / Yeer	3. Tima of Death
Kevin R. Jones	NOVEMBER 29, 1998	5:27P.M.

4a Facility Nema (If not institution, give street end number)	4b. City, Town, or Location of Deeth	4c. County of Death
5912 STEVENS FOREST	COLUMBIA	HOWARD

Funeral Director

5. Sociel Security Number	6. Sex	7. Age (In yrs, last birthday)	If Under 1 Yaar: Months / Days	If Undar 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Yaar)	9. Birthplaca (Stata or Foraign Country)
214-64-5356	1☒M 2☐F	42 Yrs.			7/13/56	MD

Usual Rasidance of Decedent

10a. Steta	10b. County	10c. City, Town or Location	10d. Insida City Limits
MD	~~NA~~ HOWARD	Columbia	1☐Yas 2☒No

10e. Street and Number	10f. Zip Coda	10g. Citizan of What Country?
5912 STEVENS FOREST #7	21045	USA

11. Marital Status	12. Was Decedent Evar in U.S. Armad Forcas? If Yas, Give Yaer or Detas:	13. Was Dacedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.)	14. Race - Amarican Indian, Black, White, atc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yas 2☒No	1☐Yas 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highast grada completed)		16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired)	16b. Kind of Businass/Industry
Elementery/Secondery (0-12)	College (1-4or 5+)		
12th	NA	SECURITY	Protection-GAS+Electric

17. Father's Neme (First, Middle, Last)	18. Mothar's Nama (First, Middla, Maidan Surnema)
William R. Jones	Sarah E. DEFord

19a. Informant's Name/Ralationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Coda)
SISTER Desiree Jones-Hayes	5912 STEVENS FOREST Rd APT 7 Columbia, MD 21045

20a. Mathod of Disposition	20b. Placa of Disposition (Nama of camatary, cramatory or othar placa)	Data	20c. Location - City or Town, Stata
1☒Burial 2☐Cremation 3☐Ramoval from Stata 4☐Donation 5☐Othar (Specify)	MT ZION	12-4-98	Lansdowne, MD

21. Signature of Funaral Sarvice Licensee	22. Nama and Address of Facility
▶	ALBERT P. Wylie F/H PA 638 N. Gilmor St. BALTIMORE MD 21217

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Entar tha disaasa, or complications thet caused the daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failure. List only one causa on aach lina.	Approximata Intarval Betwaan Onsat and Death
Immediate Causa (Final disaasa or condition resulting in daath) a. MULTIPLE DRUGS AND ALCOHOL INTOXICATION	
Due to (or as e consaquance of):	
Sequentially list conditions, if any, leading to immadiata causa. Entar Underlying Cause (Disaasa or injury that initiated avants rasulting in daath) Last: b.	
Dua to (or as a consequanca of):	
c.	
Dua to (or es e consequence of):	
d.	

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying cause given in Part I.

23b. Did tobacco usa contribute to the causa of death?	24a. Was an autopsy performed?	24b. Ware autopsy findings available prior to compiation of causa of death?
1☐Yas 2☐No 3☐Probably 4☒Unknown	1☒Yas 2☐No	1☒Yas 2☐No

25. Was casa rafarrad to medical examiner?	26. Pleca of Death (Check only ona)	
1☒Yas 2☐No	Hospital: 1☐Inpatiant 2☐ER/Outpatiant 3☐DOA	Othar: 4☐Nursing Homa 5☒Residance 6☐Othar (Specify)

27. Mannar of Daath	28a. Date of Injury (Month, Day Yaar)	28b. Tima of Injury	28c. Injury at Work?	28d. Dascribe how injury occurred
1☐Natural 2☐Accidant 3☐Suicida 4☐Homicida 5☐Panding investigation 6☒Could not be datarminad	Found: 11-29-98	Found: 5:15 P M	1☐Yas 2☒No	UNKNOWN

28e. Plece of Injury - At home, ferm, street, factory, office building, atc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, Steta)
HOME	5912 STEVENS FOREST APT. 7, COLUMBIA, HOWARD COUNTY, MD

29a. Certifier (Check only one)

1☐ **Certifying Physician:** To the best of my knowledge, daath occurred at the time, data end place, and due to the cause(s) and mannar as steted.

2☒ **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, daath occurred at tha tima, date end place, and due to tha causa(s) and manner stated.

29b. Signature and title of certifier	29c. Licansa number	29d. Data signad (Month, Dey, Yaar)
▶	O.C.M.E.	NOVEMBER 30, 1998

30. Name and address of person who compiated cause of daath (Item 23a) (Type, Print) A. M. DIXON 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Data filad (Month, Day, Yaar)	32. Registrar's Signature
DEC 04 1998	G. Sparks

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 37134

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: June Helen Hoerner Kovach

2. Date of Death — Month: Nov. Day: 20 Year: 1998

3. Time of Death: PM

4a. Facility Name *(If not institution, give street and number)*: 2 E Honeybee Court

4b. City, Town, or Location of Death: Cockeysville

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 169-32-1633

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 58 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: June 14 1940

9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Cockeysville

10d. Inside City Limits: 1☐ Yes 2☒ No

10a. Street and Number: 2 E Honeybee Court

10f. Zip Code: 21030

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+): n/a

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Bruce Eugene Hoerner

18. Mother's Name *(First, Middle, Maiden Surname)*: Alma Ruhman

19a. Informant's Name/Relationship *(Type, Print)*: Peter D. Kovach/Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 23 Lancaster Ave., Apt. 2, Ephrata, PA 17522

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Zion Lutheran Cemetery — Date: 11/28/98

20c. Location - City or Town, State: Akron, PA

21. Signature of Funeral Service Licensee: Lowell M. Lemmon

22. Name and Address of Facility: Lemmon Funeral Home, 10 W. Padonia Rd., Timonium, MD 21093

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute Coronary Occlusion

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Coronary Artery Disease

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Obesity & Depression

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☑ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☑ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Charles F. O'Donnell MD

29c. License number: D-09383

29d. Date signed *(Month, Day, Year)*: November 24, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Charles F. O'Donnell, M.D. 111 Hamlet Hill Rd., Baltimore, MD 21210

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 04 1998

32. Registrar's Signature: Penny D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

98-6967-510
DDG
ROSE B. LILLER

Amemd:20b,c Per Fh Film G766 12-7-98RC

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37135

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Rose Bell Liller
2. Date of Death (Month, Day, Year): DECEMBER 1, 1998
3. Time of Death: 0754 AM
4a. Facility Name (If not institution, give street and number): 819 EAST 22ND STREET
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: NA

Funeral Director

5. Social Security Number: 219-58-2402
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 47 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 03-25-51
9. Birthplace (State or Foreign Country): SC

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 819 E. 22nd. Street
10f. Zip Code: 21218
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 10th Grade
College (1-4or 5+): NA
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Nursing Assistant
16b. Kind of Business/Industry: Nursing Home

17. Father's Name (First, Middle, Last): Roosevelt Watson
18. Mother's Name (First, Middle, Maiden Surname): Bertha Bell

19a. Informant's Name/Relationship (Type, Print): Linda White
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 513 E. 27th Street Baltimore, Maryland 21218

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): WOODLAWN ~~Baltimore~~ Cemetery
Date: 12-07-98
20c. Location - City or Town, State: WOODLAWN ~~Baltimore~~, MD

21. Signature of Funeral Service Licensee: ▶ Bernard D Johnson
22. Name and Address of Facility: Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Asthma
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown
24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 8☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end manner as stated. 2☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Dennis J Chute MD
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): DECEMBER 1, 1998
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dennis J. Chute, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): DEC 04 1998
32. Registrar's Signature: Deputy G. Spady

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

98-6913-510
CMK
UNK.#98-266

ALBERT ALLEN LITTLE, JR.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

98 37136 Reg. No.

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Albert A. Little, Jr.
2. Date of Deeth: Month NOVEMBER Day 27, Year 1998
3. Time of Death: 1828PM
4a Facility Name (If not institution, give street end number): UNIVERSITY SHOCK TRAUMA CENTER
4b. City, Town, or Location of Death: BALTIMORE CITY
4c. County of Deeth: NA

Funeral Director

5. Social Security Number: 216-86-5323
6. Sex: 1☒M 2☐F
7. Age (In yrs. last birthday): 26 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Year): 07-23-72
9. Birthplece (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street end Number: 4012 Ridgecroft Road
10f. Zip Code: 21206
10g. Citizen of Whet Country?: USA

11. Marital Status: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Educetion (Specify only highest grade completed): Elementery/Secondary (0-12): 9th Grade; College (1-4or 5+): NA
16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Short-order cook
16b. Kind of Business/Industry: Company

17. Father's Neme (First, Middle, Last): Albert A. Little, Sr.
18. Mother's Name (First, Middle, Meiden Surneme): Sarah Cole

19a. Informent's Name/Reletionship (Type, Print): Geraldine Henson
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 4012 Ridgecroft Road Baltimore, Maryland 21206

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Neme of cemetery, crematory or other place): Kings Mem. PK. Cem.
Dete: 12-08-98
20c. Location - City or Town, Stete: Randallstown, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name end Address of Feciility: WM.C.March FH 1101 E. North Avenue Baltimore, Maryland 21202

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. (Approximate Intervel Between Onset end Death)

Immediate Cause (Final diseese or condition resulting in deeth): e. Gunshot wound of chest
Due to (or es e consequence of):
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last:
b.
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Pert II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobecco use contribute to the cause of deeth? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Wes en eutopsy performed? 1☒Yes 2☐No
24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? 1☒Yes 2☐No

25. Wes cese referred to medical exeminer? 1☒Yes 2☐No
26. Plece of Death (Check only one): Hospitel: 1☐Inpetient 2☒ER/Outpetient 3☐DOA; Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)
27. Manner of Deeth: 1☐Neturel 2☐Accident 3☐Suicide 4☒Homicide 5☐Pending Investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year): 11-27-98
28b. Time of Injury: 1726 M
28c. Injury et Work? 1☐Yes 2☒No
28d. Describe how injury occurred: Subject was shot
28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify): Street
28f. Location (Street end Number or Rural Route Number, City or Town, State): 100 Poppleton St. Baltimore City, Maryland

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner es steted.
2☒ **Medicel Examiner:** On the basis of exeminetion end/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) end menner steted.

29b. Signature and title of certifier: [signature]
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): NOVEMBER 28, 1998

30. Name end eddress of person who completed ceuse of deeth (Item 23a) (Type, Print): Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Dey, Year): DEC 04 1998
32. Registrer's Signeture: [signature]

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To be Completed by Funeral Director

permit. Pages 1 end 2 should be filled within 72 hours after death with the Maryland Department of Health end Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37137

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARY LEWIS
2. Dete of Deeth: Month 12 Dey 1 Yaer 98
3. Time of Death: 10 30 AM
4a Facility Nama (If not institution, giva street and number): 7161 FAIRBROOK ROAD
4b. City, Town, or Location of Deeth: N/A
4c. County of Deeth: BALTIMORE

Funeral Director

5. Social Sacurity Numbar: 215-09-0123
6. Sax: 1☐ M 2☑ F
7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Yeer): 3-15-11
9. Birthplace (State or Foreign Country): MD

Usuel Residence of Decedent

10e. Stete: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street end Number: 1400 E. MADISON STREET
10f. Zip Code: 21205
10g. Citizen of Whet Country?: USA

11. Maritel Status: 1☐ Never Married 2☐ Married 3☑ Widowad 4☐ Divorcad
12. Was Decedent Ever in U.S. Armed Forces?: 1☐ Yes 2☑ No If Yas, Give Yeer or Detas:
13. Was Decedent of Hispenic Orlgin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puarto Rican, etc.): 1☐ Yes 2☑ No Specify:
14. Raca - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highast grede completed): Elementery/Secondary (0-12): 8TH GRADE | College (1-4or 5+): N/A
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): HOUSE KEEPING
16b. Kind of Business/Industry: HOTEL

17. Father's Neme (First, Middle, Last): UNKNOWN
18. Mother's Neme (First, Middle, Meiden Sumame): DELLA WILLIAMS

19e. Informent's Name/Reletionship (Type, Print): CORITA GERVAIS / DAUGHTER
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 7161 FAIRBROOK RD. BALTO. MD. 21244

20e. Methad of Disposition: 1☑ Burial 2☐ Cremetion 3☐ Removal from Stete 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other place): KING MEMORIAL PARK
Date: 12-5-98
20c. Location - City or Town, Stete: RANDALLSTOWN, MD

21. Signature of Funeral Service Licensee: Vaughn C Greene
22. Neme end Addrass of Facility: VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL' PIKE, BALTO. MD. 21229

Physician /Medical Examiner

23a. Pert1. Entar the disease, or complications that causad tha daath. Do not antar the mode of dying, such as cardiac or raspiratory errest, shock, or heart failure. List only one ceuse on eech line.

Approximete Intervel Between Onsat and Deeth

Immediata Cause (Final diseese or condition resulting in deeth): e. metastatic Colon/sigmoid cancer — 6 years
Due to (or es e consequence of):

Sequentially list conditions, if any, leeding to immadiate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest:
b.
Due to (or es e consequenca of):
c.
Dua to (or as e consequence of):
d.

Pert II. **Other significent conditions** contributing to death but not rasulting in the underlying cause given in Pert I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was case referred to medicel examinar? 1☐ Yes 2☒ No
26. Piece of Deeth (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other (Specify) daughter's home

27. Manner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28e. Dete of Injury (Month, Dey Year)
28b. Tima of Injury
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physicfan:** To the best of my knowledge, death occurred et the time, date end piece, end due to the ceuse(s) end menner es steted. 2☐ **Medicaf Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end piece, end due to the cause(s) end mennar steted.

29b. Signatura and titla of certifiar: Linda L. Yau M.D.
29c. License number: D51842
29d. Date signed (Month, Day, Year): December 4, 1998

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): Linda L. Yau M.D. 1000 E. Eager St. Baltimore MD 21202 East Baltimore Medical Center

State Registrar

31. Data filed (Month, Day, Year): DEC 04 1998
32. Registrar's Signature: Regina D. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificata be axecuted within 24 hours eftar death.
To the Funeral Director: After this certificate has been signed by the attanding physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

98-6918-033
DDG
LIU AN DI

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 37138

Items:20a,b,c per F.H G-766 12/8/98 reb

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): AN Di LIU

2. Date of Death: Month NOVEMBER Day 27, Year 1998

3. Time of Death: 2125 PM

4a Facility Name (If not institution, give street and number): 21 C STREET

4b. City, Town, or Location of Death: LAUREL

4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: NONE

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 42 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): SEPT. 26, 1956

9. Birthplace (State or Foreign Country): CHINA

Usual Residence of Decedent

10a. State: MD

10b. County: PRINCE GEORGES

10c. City, Town or Location: LAUREL

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 21 C STREET

10f. Zip Code: 20707

10g. Citizen of Whet Country? CHINA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: ASIAN

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): FOOD DELIVERY DRIVER

16b. Kind of Business/Industry: RESTAURANT

17. Father's Name (First, Middle, Last): UNKNOWN

18. Mother's Name (First, Middle, Maiden Surname): UNKNOWN

19a. Informant's Name/Relationship (Type, Print): ZHAO AN LI (BROTHER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 180 MULBERRY ST. APT 3B N.Y. 10012 N.Y.

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Greenway Cemetery ROSE HILL CEMETERY

Date: 12/23/98 12-11-98

20c. Location - City or Town, State: Brooklyn, New York LINDEN New Jersey

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: DELLA NOCE & SONS FUNERAL HOME 322 S. HIGH ST. BALTO 21202 Md.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Hanging

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☒ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year): 11-27-98

28b. Time of Injury: unknown M

28c. Injury at Work? 1☐ Yes 2☒ No

28d. Describe how injury occurred: subject hanged himself

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Residence

28f. Location (Street and Number or Rural Route Number, City or Town, State): 21 C Street Prince Georges County, Maryland

29a. Certifier (Check only one): 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated. 2☒ **Medical Examiner**: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] Alizabeth A Mackey, MD

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): NOVEMBER 28, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): DEC 04 1998

32. Registrar's Signature: [signature] Geneva G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

ab3

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37139

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Viola Miles
2. Date of Death: Month DECEMBER Day 01 Year 1998
3. Time of Death: 09:33PM
4a. Facility Name (If not Institution, give street and number): THE JOHNS HOPKINS HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE CITY
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 231-26-5717
6. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthday): 73 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 8-31-25
9. Birthplace (State or Foreign Country): VA

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street and Number: 1621 RUXTON AVENUE
10f. Zip Code: 21216
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☑ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 TH GRADE; College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SWITCH BOARD SUPERVISOR
16b. Kind of Business/Industry: TELEPHONE Co.

17. Father's Name (First, Middle, Last): NEIL WILLIAM SCOTT
18. Mother's Name (First, Middle, Maiden Surname): VIOLA JONES

19a. Informant's Name/Relationship (Type, Print): NELSON MILES
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1621 RUXTON AVENUE, BALTO. MD. 21216

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): KING PARK CEMETERY
Date: 12-7-98
20c. Location - City or Town, State: RANDALLSTOWN, MD

21. Signature of Funeral Service Licensee: ▶ Vaughn C Greene
22. Name and Address of Facility: VAUGHN C. GREENE FUNERAL SER. 5151 BALTO. NATL PIKE, BALTO. MD. 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Pneumonia — One Month
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure
Coronary Artery Disease
Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ WGF M.D.
29c. License number: RES-000
29d. Date signed (Month, Day, Year): December 1, 1998

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Whittemore G. Fingley, Johns Hopkins Hospital, Tower 110

State Registrar

31. Date filed (Month, Day, Year): DEC 04 1998
32. Registrar's Signature: ▶ Barbara B. Hooker

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that this death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use by the burial-transit

Division of Vital Records, P.O. Box 68760,

10

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37140

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Vivian Baker McMaster

2. Date of Death — Month: Nov. Day: 25 Year: 1998

3. Time of Death: 5:05 PM

4e Facility Name *(If not institution, give street and number)*: 426 Sherwood Road

4b. City, Town, or Location of Death: Cockeysville

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 219-42-7443

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 86 Yrs.

If Under 1 Year — Months: Days: If Under 24 Hrs. — Hours: Min.:

8. Date of Birth *(Month, Day, Year)*: July 13 1912

9. Birthplace *(State or Foreign Country)*: Maryland

Usuel Residence of Decedent

10e. Stete: MD

10b. County: Baltimore

10c. City, Town or Location: Cockeysville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 426 Sherwood Road

10f. Zip Code: 21030

10g. Citizen of What Country?: USA

11. Meritel Status: 1☐ Never Merried 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)* — Elementary/Secondary (0-12): 12 College (1-4or 5+): n/a

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Fether's Neme *(First, Middle, Last)*: Bishop F. Baker

18. Mother's Name *(First, Middle, Maiden Surname)*: Lillian A. O'Connor

19e. Informent's Name/Reletionship *(Type, Print)*: Kimberly A. McCarty

19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 91 Laurel Dr., Stewartstown, PA 17363

20e. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, cremetory or other piece)*: Dulaney Valley Memorial Gardens Date: 12/1/98

20c. Location - City or Town, State: Timonium, MD

21. Signature of Funeral Service Licensee: Michael J. Flagle

22. Name and Address of Fecility: Lemmon Funeral Home 10 W. Padonia Rd., Timonium, MD 21093

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, sheck, or heert failure. List only one cause on each line.

Approximete Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death): a. CANCER OF THE PANCREAS

Due to (or es a consequence of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Lest

b. Due to (or as e consequence of):

c. Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: C.O.P.D

23b. Did tobecco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings aveilable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth *(Check only one)* — Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined

28a. Dete of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) end manner es stated. 2☐ **Medical Examiner:** On the besis of examination end/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) end menner steted.

29b. Signature and title of certifier: Raymond A. Nze MD

29c. License number: D34184

29d. Date signed *(Month, Day, Year)*: 11/30/98

30. Neme end address of person who completed cause of deeth (Item 23a) (Type, Print): Raymond A. Nze, M.D. 7801 York Rd., Suite 100, Towson, MD

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: DEC 04 1998

32. Registrer's Signeture: G. Sparks

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ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1 page

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 37141

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Isabella Marie Mangum

2. Date of Death: Month: November Day: 29 Year: 1998

3. Time of Death: 9:00 P.M.

4a. Facility Name (If not institution, give street and number): 314 Townsend Avenue

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 217 52 3306

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 85 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 19, 1913

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 314 Townsend Avenue

10f. Zip Code: 21225

10g. Citizen of What Country?: U.S.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 5th; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): John A. Pachmayr

18. Mother's Name (First, Middle, Maiden Surname): Isabella M. Janssens

19a. Informant's Name/Relationship (Type, Print): Charles Mangum / son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 314 Townsend Avenue Baltimore, Maryland 21225

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Cedar Hill Cemetery

Date: 12/3/98

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Donna M Zaremowski

22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part I. Enter the disease, all complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pneumonia — 1 WK

Due to (or as a consequence of):
b.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Cerebrovascular accident

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Afroze Muneer

29c. License number: D45105

29d. Date signed (Month, Day, Year): 11/30/98

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): AFROZE MUNEER 901 E. FORT AVE BALTIMORE MD 21230

State Registrar

31. Date filed (Month, Day, Year): DEC 04 1998

32. Registrar's Signature: Geneva G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 37142

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Anthony Mazzaro
2. Date of Death Month / Day / Year: December 1, 1998
3. Time of Death: 7:55 AM
4a. Facility Name *(If not institution, give street and number)*: Northwest Hospital
4b. City, Town, or Location of Death: Randallstown
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 302-20-7688
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 68 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Yaer)*: June 13, 1930
9. Birthplace *(State or Foreign Country)*: Ohio

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Reisterstown
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 816 Ivy Dale Ave.
10f. Zip Code: 21136
10g. Citizen of Whet Country?: U.S.A.

11. Maritel Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U.S. Armed Forces?: 1 [X] Yes 2 [ ] No — If Yes, Give Yeer or Dates: 1948-1953
13. Was Decedant of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Bleck, White, etc. *Specify:* White
15. Decedanl's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; Collaga (1-4or 5+): 1
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working lifa. DO NOT use retired)*: Engineer
16b. Kind of Businass/Industry: Electronics Co.
17. Fether's Neme *(First, Middle, Last)*: Joseph Mazzaro
18. Mother's Nama *(First, Middle, Maiden Surname)*: Grace Schweitzer
19a. Informent's Name/Reletionship *(Type, Print)*: Janice F. Mazzaro Wife
19b. Mailing Address *(Street and Number or Rurel Routa Numbar, City or Town, Stata, Zip Code)*: 816 Ivy Dale Ave., Reisterstown, Md. 21136
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from Stete 4 [ ] Donetion 5 [ ] Other *(Specify)*
20b. Pleca of Disposition *(Name of cemetary, crametory or other place)*: Evergreen Memorial Gardens
Dete: 12/5/98
20c. Location - City or Town, State: Finksburg, Md
21. Signature of Funeral Service Licensee: [signature]
22. Name end Address of Facility: 11824 Reisterstown Rd. Eline Funeral Home Reisterstown, Md. 21136

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one ceuse on eech line. — Approximate Intervel Between Onset end Death

Immediate Ceuse (Final diseasa or condition resulting in daath)
a. Respiratory failure
Dua to (or as e consequence of):
b. End stage of Emphysema
Due to (or es e consequenca of):
c.
Due to (or es e consequenca of):
d.

Sequentially list conditions, if eny, laading to immediata causa. Enter Underlying Cause (Disaasa or injury that initieted events resulting in deeth) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No
24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical exeminer? 1 [ ] Yes 2 [X] No
26. Pleca of Death *(Check only one)*: Hospital: 1 [X] Inpatiant 2 [ ] ER/Outpetiant 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Rasidanca 6 [ ] Other *(Specify)*
27. Manner of Daath: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Panding investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, straet, factory, offica building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stata)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, daath occurred et the time, date end place, end due to the cause(s) end menner es steted. 2 [ ] **Medical Examiner**: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and pleca, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: H43974
29d. Date signed *(Month, Dey, Year)*: December 1, 1998

30. Neme end eddress of person who completed cause of daeth (Item 23e) (Type, Print): Alice Hsieh Northwest Hospital Randallstown, Md

State Registrar

31. Dete filed *(Month, Dey, Year)*: DEC 04 1998
32. Registrar's Signature: [signature]

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached and used as the burial-transit permit.

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37143

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Orville Leroy MicKey
2. Data of Deeth — Month: Nov. Dey: 30 Yeer: 1998
3. Time of Death: 10:50AM
4a. Facility Nema *(If not institution, giva straet and number)*: Genesis Eldercare
4b. City, Town, or Location of Death: Baltimore
4c. County of Deeth: Baltimore

Funeral Director

5. Social Security Number: 216-14-0589
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 77 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Dey, Year)*: Oct.14,1921
9. Birthplece *(Stata or Foreign Country)*: Baltimore,Md.

Usuel Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street end Number: 3500 Linbelle Terrace
10f. Zip Code: 21234
10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1 [ ] Never Marriad 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: Air Force
13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Race - Amarican Indian, Black, White, etc. *Specify:* White

15. Decedent's Educetion *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12 yrs. — College (1-4or 5+): 4yrs.
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Electrician
16b. Kind of Businass/Industry: Electrical Industry

17. Father's Name *(First, Middle, Last)*: Harry Mickey
18. Mother's Name *(First, Middle, Maidan Surname)*: Blanche Nusbaum

19a. Informent's Name/Reletionship *(Type, Print)*: Mrs. Sarah Mickey (Wife)
19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 3500 Linbelle Terrace Baltimore,Maryland 21234

20a. Method of Disposition: 1 [X] Buriel 2 [ ] Cremetion 3 [ ] Ramovel from State 4 [ ] Donetion 5 [ ] Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, crematory or othar place)*: Dulaney Valley Mem.Grds. — Date: 12/4/98
20c. Locetion - City or Town, Stete: Towson,Maryland 21204

21. Signeture of Funeral Service Licensee: E. F. Lassahn
22. Name and Address of Facility: E. F. Lassahn Funeral Home 11750 Belair Road Kingsville, Md. 21087

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiena.
Important: If Item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

ORVille MicKey

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the daath. Do not antar tha mode of dying, such as cerdiac or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Deeth

Immediata Causa (Final diseese or condition resulting in death)
a. CEREBRO VASCULAR ACCIDENT — 2 hrs

Due to (or es a consequence of):
b. ATHEROSCLEROTIC VASCULAR DISEASE —

Sequentially list conditions, if eny, leading to immediata ceuse. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Last

Due to (or as a consequence of):
c.

Due to (or es a consequence of):
d.

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying ceuse given in Pert I.: DIABETES MELLITUS TYPE 1

23b. Did tobacco use contribute to the cauee of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was en eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings eveileble prior to completion of ceuse of deeth? 1 [ ] Yes 2 [ ] No

25. Was cese referred to medicel examiner? 1 [ ] Yes 2 [X] No

26. Piece of Deeth *(Check only one)*: Hospitel: 1 [ ] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA — Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Deeth: 1 [X] Naturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Spacify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Phyeician:** To the best of my knowledge, death occurred et the time, date end piece, end due to the ceuse(s) and manner es stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and menner stated.

29b. Signature and title of certifier: Charles F. Adams MD
29c. License number: D20390
29d. Date signed *(Month, Dey, Year)*: 12/1/98

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print): CHARLES HOESCH 9712 BELAIR RD PERRY HALL MD. 21128

To the Hospital or Attending Physician: The law requires that tha daath certificate be executed within 24 hours efter death.
To tha Funeral Director: Aftar this certificate has been signed by the attending physician and completely filled in by the funaral director, page 2 should be datached for use as the burial-transit

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 04 1998
32. Registrer's Signature: G. Sparks

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37144

Physician /Medical Examiner

1. Decedent's Nema *(First, Middle, Last)*: Alma Viola McFaul
2. Date of Death Month / Day / Year: 12/2/98
3. Time of Death: 1:00am
4a. Facility Nama *(If not institution, give street and number)*: 8632 Jessica Lane
4b. City, Town, or Location of Death: Perry Hall
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 214-14-0488
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 83 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: June 1, 1915
9. Birthplace *(State or Foreign Country)*: Maryland

Usuel Residence of Decedent

10a. Steta: Maryland
10b. County: Baltimore
10c. City, Town or Location: Perry Hall
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 8632 Jessica Lane
10f. Zip Code: 21128
10g. Citizen of What Country?: United States

11. Maritel Stetus: 1☐ Nevar Marriad 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yas 2☒ No — If Yes, Give Year or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 8th — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Fether's Nema *(First, Middle, Last)*: Edward Appel
18. Mother's Name *(First, Middle, Maiden Surname)*: Alma Viola Thomas

19a. Informent's Name/Relationship *(Type, Print)*: Mary Ellen Reichert/daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 9911 Belair Road Kingsville, Maryland 21087

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: Gardens of Faith Cemetery — Date: 12/5/98
20c. Location - City or Town, State: Baltimore, Maryland

21. Signeture of Funeral Service Licensee: Juanita R Thomas
22. Name and Address of Facility: John C. Miller, Inc. 6415 Belair Road Baltimore, Maryland 21206

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications thet caused tha death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heert failure. List only one cause on eech line. — Approximate Interval Between Onset and Death

Immediata Ceuse (Finel diseese or condition resulting in death):
a. TRANSITIONAL CELL CARCINOMA Bladder.
Due to (or as a consequence of):
b.
Due to (or es a consequence of):
c.
Due to (or es a consequence of):
d.

Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Hypertension; Cerebral vascular accident

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined
28a. Dete of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signatura and title of certifier: ▶ Hilary Don MD
29c. License number: D35102
29d. Date signed *(Month, Day, Year)*: December 3 1998

30. Nema and address of person who completed cause of death (Item 23a) (Type, Print): Hilary Don M.D. 3400 Brehms Lane Baltimore MD. 21213

State Registrar

31. Data filed *(Month, Dey, Year)*: DEC 04 1998
32. Registrar's Signature: ▶ D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by tha funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37145

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: CLARENCE G. NORRIS

2. Date of Death — Month: DEC. Day: 1 Year: 1998

3. Time of Death: 6:10 AM

4a. Facility Name *(If not institution, give street end number)*: GENESIS ELDER CARE LOCH RAVEN

4b. City, Town, or Location of Death: TOWSON

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 218-03-9543

8. Sex: 1☒M 2☐F

7. Age *(In yrs. last birthday)*: 82 Yrs.

If Under 1 Year — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Date of Birth *(Month, Day, Year)*: 12/31/15

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MD

10b. County: BALTIMORE

10c. City, Town or Location: TOWSON

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street end Number: 8303 OAKLEIGH ROAD

10f. Zip Code: 21234

10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*

Elementary/Secondary (0-12): 12th GRADE

College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: FOREMAN

16b. Kind of Business/Industry: BRICKYARD

17. Father's Name *(First, Middle, Last)*: CLARENCE NORRIS

18. Mother's Name *(First, Middle, Maiden Surname)*: VIOLA LANCE

19a. Informant's Name/Relationship *(Type, Print)*: GAYLE PLANTHOLT DAUGHTER

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 8303 OAKLEIGH ROAD BALTIMORE, MD 21234

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: DULANEY VALLEY MEM. GAR.

Date: 12/4/98

20c. Location - City or Town, State: COCKEYSVILLE, MD

21. Signature of Funeral Service Licensee ▶

22. Name and Address of Facility: THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CA OF LUNG.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. COPD

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐Yes 2☐No 3☐Probably 4☑Unknown

24a. Was an autopsy performed? 1☐Yes 2☑No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☑No

26. Place of Death *(Check only one)*

Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA

Other: 4☑Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier ▶

29c. License number: D52739

29d. Date signed *(Month, Day, Year)*: 12/3/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Shanldya , MD 3007 E. Northern Parkway Baltimore, MD 21214

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 04 1998

32. Registrar's Signature ▶ Anne G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37146

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: LILLIE LEE (PAINTER) NUCKOLES

2. Date of Death Month Day Year: November 29, 1998

3. Time of Death: 8:00am

4a Facility Name *(If not institution, give street and number)*: 2413 Chetwood Circle

4b. City, Town, or Location of Death: Timonium

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 227-18-1100

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 91 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Oct 10, 1907

9. Birthplace *(State or Foraign Country)*: Virginia

Usual Residence of Decedent

10a. State: Virginia

10b. County: NONE

10c. City, Town or Location: STAUNTON

10d. Insida City Limits: 1☒ Yes 2☐ No

10a. Street and Number: 330 Marr Street

10f. Zip Code: 24401

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): unknown; College (1-4or 5+): n/a

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Seamstress

16b. Kind of Business/Industry: Coat Factory

17. Father's Name *(First, Middle, Last)*: Arthur David Painter

18. Mother's Name *(First, Middle, Maiden Surname)*: Texie Anna Campbell

19a. Informant's Name/Relationship *(Type, Print)*: Mary N. Hickey/Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2413 Chetwood Circle, Timonium, MD 21093

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Thornrose Cemetery

Date: 12/2/98

20c. Location - City or Town, State: Staunton, Virginia

21. Signature of Funeral Service Licensee: ▶ Bryan W. Clary

22. Name and Address of Facility: Lemmon Funeral Home 10 W. Padonia Road, Timonium, MD 21093

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arresl, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Atrial Fibrilation

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Pulmonary Fibrosis

Due to (or as a consequence of):

c. Pneumonia

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* Daughter's Residence

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to tha cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Alabrash

29c. License number: D 37612

29d. Date signed *(Month, Day, Year)*: 11/30/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Mohamad Alabrash, MD 9712 Belair Rd., suite 302, Perry Hall, Maryland 21236

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 04 1998

32. Registrar's Signature: ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37147

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARGARET UPCHURCH NICHOLLS.

2. Date of Death — Month: NOV Day: 30 Year: 1998

3. Time of Death: 01:20 HRS

4a. Facility Name *(If not institution, give street and number)*: ER FALLSTON GENERAL HOSP

4b. City, Town, or Location of Death: FALLSTON

4c. County of Death: HARFORD.

Funeral Director

5. Social Security Number: 223-01-5689

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 81 Yrs.

If Under 1 Year — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Date of Birth *(Month, Day, Year)*: October 2, 1917

9. Birthplace *(State or Foreign Country)*: Richmond, Virginia

Usual Residence of Decedent

10a. State: Virginia

10b. County: Henrico

10c. City, Town or Location: Richmond Virginia

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 905 West 49th Street

10f. Zip Code: 23225

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 Years; College (1-4or 5+): N/A

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Secretary

16b. Kind of Business/Industry: Real Estate

17. Father's Name *(First, Middle, Last)*: Frederick Upchurch

18. Mother's Name *(First, Middle, Maiden Surname)*: Ruby Farmer

19a. Informant's Name/Relationship *(Type, Print)*: Malcolm R. Nicholls - Husband

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 905 West 49th Street - Richmond, Virginia - 23225

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Maury Cemetery — Date: Dec.4,1998

20c. Location - City or Town, State: Richmond Virginia

21. Signature of Funeral Service Licensee: Donald C. Lassahn

22. Name and Address of Facility: Lassahn Funeral Home, 7401 Belair Road - Baltimore, Maryland 21236-4625

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ASHD.

Due to (or as a consequance of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: HYPERTENSION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*: NA

28b. Time of Injury: NA M

28c. Injury at Work? 1☐ Yes 2☐ No: NA

28d. Describe how injury occurred: NA

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: NA

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: NA

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: DME

29c. License number: OCME

29d. Date signed *(Month, Day, Year)*: NOV 30 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GPNABHU 218 FULFORD AVE BELAIR MD 21014 410-879-6564

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 04 1998

32. Registrar's Signature: Penny B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37148

ROBERT LOUIS PHILLIPS NOVEMBER 26, 1998
Baltimore, Maryland 21215-0020
10:40 pm

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Data of Death Month / Day / Yaar	3. Tima of Daath
Robert Louis Phillips	11 / 26 / 1998	10 41P.M.

4a. Facility Neme (If not institution, give street and number)	4b. City, Town, or Locatlon of Deeth	4c. County of Death
Stella Maris Towson	Towson	Baltimore

Funeral Director

5. Social Security Numbar	6. Sex	7. Aga (In yrs. last birthday)	If Undar 1 Yaar: Months / Days	If Undar 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (Stata or Foraign Country)
215-60-4603	1☒ M 2☐ F	46 Yrs.			8 -12-1952	Md

To Be Completed by Funeral Director

Usual Rasidance of Dacedant

10a. State	10b. County	10c. City, Town or Location	10d. Insida City Limits
Md	N/A	Baltimore	1☒ Yas 2☐ No

10e. Straat end Number	10f. Zip Coda	10g. Citizan of What Country?
2502 Eutaw Place	21216	U S A

11. Marital Status	12. Was Dacedent Ever in U.S. Armed Forcas?	13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxicen, Puarto Ricen, atc.)	14. Race - Amarican Indian, Black, Whita, atc.
1☒ Navar Married 2☐ Married 3☐ Widowed 4☐ Divorced	1☐ Yas 2☒ No If Yas, Giva Yeer or Datas:	1☐ Yas 2☒ No Specify:	Specify: Black

15. Decedant's Educetion (Spacify only highast grada complatad)		16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratirad)	16b. Kind of Businass/Industry
Elamantary/Secondary (0-12)	Collaga (1-4or 5+)		
12th grade	N/A	Mental Health Care Counselor	Progressive Horizon

17. Fathar's Name (First, Middle, Last)	18. Mothar's Name (First, Middle, Maidan Surnama)
James E. Phillips	Barbara Tyler

19a. Informant's Name/Ralationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda)
Pamela Phillips - Sister	3915 Liberty Heights Apt B1 Baltimore, Md 21207

20a. Mathod of Disposition	20b. Place of Disposition (Name of cemetery, crematory or othar place)	Dete	20c. Location - City or Town, Stata
1☒ Burial 2☐ Cremation 3☐ Ramovel from State 4☐ Donation 5☐ Othar (Spacify)	King Memorial Park	12-3-98	Randallstown, Md

21. Signature of Funeral Service Licensee ▶ Lynette K. Innes

22. Nama and Address of Facility
March F/H West
4300 Wabash Avenue Baltimore, Md 21215

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused tha daath. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or haart failure. List only one cause on each lina. — Approximata Intarval Batwaan Onsat and Death

Immadiata Cause (Final disaasa or condition rasulting in daath)
a. END_STAGE RENAL CELL CANCER

Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Disaasa or injury that initiatad avants rasulting in daath) Last
b. Due to (or as a consequance of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying causa givan in Part I.

23b. **Did tobacco use contributa to the causa of death?** 1☐ Yas 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy parformed?	24b. Wara autopsy findings availabla prior to compiation of ceuse of daath?
1☐ Yas 2☒ No	1☐ Yas 2☐ No

25. Was cesa rafarrad to medical examinar?	26. Placa of Daath (Chack only ona)	
1☐ Yas 2☒ No	Hospital: 1☐ Inpatiant 2☐ ER/Outpatiant 3☐ DOA	Othar: 4☐ Nursing Homa 5☐ Rasidance 6☒ Othar (Specify) HOSPICE

27. Mannar of Death	28a. Data of Injury (Month, Day Yaar)	28b. Tima of Injury	28c. Injury at Work?	28d. Dascribe how injury occurrad
1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be datarminad		M	1☐ Yas 2☐ No	

28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Cartifiar (Check only one)
1☒ **Cartifying Physician:** To tha best of my knowladga, daath occurrad at tha tima, data and place, and dua to tha causa(s) and mannar as statad.
2☐ **Madical Examinar:** On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at tha tima, data and place, and dua to tha causa(s) and mannar stated.

29b. Signeture and titla of certifiar	29c. Licansa number	29d. Data signed (Month, Day, Year)
▶	D43725	11/27/98

30. Nama and addrass of person who complated ceusa of daath (Item 23a) (Type, Print)
DR. TARIQ MAHMOOD, 2300 DULANEY VALLEY ROAD, TIMONIUM, MD 21093

State Registrar

31. Data filad (Month, Day, Year)	32. Registrar's Signatura
DEC 04 1998	▶ Geneva B. Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

2 pgs

DHMH 16 Rev 6/95

Chapter 4 Pages

98-7023-510
ARDWIN PARKER
ASP

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Items: 23part I, 27, 28a-f per MEO G-766 12/8/98 reb

Certificate of Death

Reg. No. 98 37149

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
AUDWYN PARKER	DECEMBER 02 1998	1939 P

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
JOHNS HOPKINS HOSPITAL	BALTIMORE	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months / Days	If Under 24 Hrs. Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
579-92-0172	1☒ M 2☐ F	28 Yrs.			JAN. 14, 1970	WASHINGTON D.C.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.	N/A	BALTIMORE CITY	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
317 E. NORTH AVE APT 401	21213	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Yeer or Detes:	1☐ Yes 2☒ No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondary (0-12)	College (1-4or 5+)		
12	N/A	COUNSELLOR	EDUCATION

17. Fether's Neme (First, Middle, Last)	18. Mother's Name (First, Middle, Meiden Surname)
TYRONE WHATLEY	BARBARA FOWLKES

19e. Informent's Neme/Reletionship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code)
BARBARA FOWLKES (MOTHER)	219 S. SPRING CT. BALTO. 21231 MD.

20e. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other piece)	Date	20c. Location - City or Town, State
1☐ Buriel 2☒ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)	METRO CREMATORY	12-5-98	BALTO. MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
	DELLA NOCE & SONS FUNERAL HOME 322 S HIGH ST. BALTO. 21202 MD.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one ceuse on eech line.

		Approximate Interval Between Onset end Death
Immediate Ceuse (Final diseese or condition resulting in deeth)	a. Narcotic and cocaine intoxication	
Sequentielly list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Last	Due to (or es e consequence of): b.	
	Due to (or es a consequence of): c.	
	Due to (or es e consequence of): d.	

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert t.

23b. Did tobacco use contribute to the cause of death?	24a. Was an eutopsy performed?	24b. Were eutopsy findings available prior to completion of cause of deeth?
1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown	1☒ Yes 2☐ No	1☒ Yes 2☐ No

25. Was case referred to medical exeminer?	26. Place of Deeth (Check only one)	
1☒ Yes 2☐ No	Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☒ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death	28a. Dete of Injury (Month, Dey Yeer)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1☐ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☒ Could not be determined	found 12/2/98	unknown M	1☐ Yes 2☒ No	subject ingested drugs

28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify): found at home

28f. Location (Street end Number or Rural Route Number, City or Town, Stete): 317 E. North Ave. Baltimore, Md.

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end menner es steted.
2☒ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end piece, end due to the cause(s) end menner steted.

29b. Signeture and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Stephen L. Radentz, MD	O.C.M.E	DECEMBER 03, 1998

30. Neme end address of person who completed cause of death (Item 23a) (Type, Print): Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed (Month, Dey, Yeer)	32. Registrar's Signeture
DEC 04 1998	G. Sparks

DHMH 16 Rev 6/95

~1000

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mentel Hygiene.
Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriel-transit

98-6970-510
DDG
GWENDOLYN PINNOX

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 37150

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Gwendolyn M. Pinnix
2. Date of Death (Month, Day, Year): DECEMBER 1, 1998
3. Time of Death: 0712 AM
4a. Facility Name (If not institution, give street and number): SHOCK TRAUMA UNIT
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death:

Funeral Director

5. Social Security Number: 220-78-5830
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 37 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 7, 1961
9. Birthplace (State or Foreign Country): Washington DC

Usual Residence of Decedent

10a. State: MD.
10b. County: Howard
10c. City, Town or Location: West Friendship
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2751 Wynfield Road
10f. Zip Code: 21794
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4or 5+): 5+
18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired): professional engineer
16b. Kind of Business/Industry: Bovis Construction

17. Father's Name (First, Middle, Last): Earl F. Gill
18. Mother's Name (First, Middle, Maiden Surname): Dolores Gill

19a. Informant's Name/Relationship (Type, Print): Duane Pinnix, husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1005 Guy Drive, Glen Burnie, Md. 21061

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): St. Louis Cemetery
Date: 12/5/98
20c. Location - City or Town, State: Clarksville, Md.

21. Signature of Funeral Service Licensee: ▶ Wanda L Lemmer
22. Name and Address of Facility: Witzke Funeral Home, Inc. of Columbia 5555 Twin Knolls Rd., Columbia, Md. 21045

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Multiple Injuries
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year): 12-1-98
28b. Time of Injury: 0614 M
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: Drive - auto - Auto collision
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Roadway
28f. Location (Street and Number or Rural Route Number, City or Town, State): Rt 32

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): DECEMBER 2, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David R Fowler 111 Penn Street, Baltimore, Maryland 21201

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): DEC 04 1998
32. Registrar's Signature: ▶ Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37151

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month / Day / Year	3. Time of Death
KATIE	PRESTIANNI	12/01/1998	1712

4a. Facility Name (If not Institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
ST. AGNES NURSING & REHAB. CENTER	ELLICOTT CITY	HOWARD

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-46-9218	1☐ M 2☒ F	94 Yrs.			03/16/1904	MARYLAND

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	HOWARD	ELLICOTT CITY	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of Whet Country?
9334 MILLBROOK ROAD	21042	U.S.A.

11. Marital Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Bleck, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Educetion (Specify only highest grade completed)		16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
6		HOMEMAKER	OWN HOME

17. Fether's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surneme)
PIETRO LIBERTO	MARIETTA BROCATO

19a. Informent's Name/Reletionship (Type, Print)	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)
SAM PRESTIANNI/SON	9334 MILLBROOK ROAD ELLICOTT CITY, MD 21042

20a. Method of Disposition	20b. Piece of Disposition (Name of cemetery, cremetory or other piece)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	NEW CATHEDRAL CEMETERY	12/5/98	BALTIMORE, MD

21. Signature of Funeral Service Licensee	22. Name end Address of Facility
▶ Phillip Hale	STERLING-ASHTON-SCHWAB FUNERAL HOME, INC. 736 EDMONDSON AVE. CATONSVILLE, MD 21228

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

		Approximete Interval Between Onset end Death
Immediate Cause (Final diseese or condition resulting in death)	e. Sepsis	2days
	Due to (or as a consequence of):	
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in deeth) Lest	b. Gangrene of foot	months
	Due to (or es e consequence of):	
	c. Peripheral Vascular Disease	years
	Due to (or as a consequence of):	
	d.	

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

Deneria

23b. Did tobacco usa contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was en eutopsy performed?	24b. Were eutopsy findings available prior to completion of cause of deeth?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was cese referred to medicel examiner?	26. Piece of Death (Check only one)	
1☐ Yes 2☐ No	Hospitel: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA	Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Deeth	28e. Dete of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined	N/A	M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street end Number or Rural Route Number, City or Town, State)
	N/A			

29a. Certifier (Check only one) 1☑ **Certifying Physicien:** To the best of my knowledge, deeth occurred et the time, date and place, end due to the ceuse(s) and menner es steted.
2☐ **Medicel Examiner:** On the besis of examination and/or investigetion, In my opinion, death occurred et the time, dete and place, and due to the ceuse(s) end manner stated.

29b. Signeture end title of certifier	29c. License number	29d. Date signed (Month, Day, Yeer)
▶ Charles Ryland MD	024781	12/2/98

30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print)

716 MAIDEN CHOICE LANE, BALTO. MD 21228

State Registrar

31. Date filed (Month, Day, Year)	32. Registrer's Signeture
DEC 04 1998	Jenna G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 37152

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Mildred Price
2. Date of Death Month / Day / Year: 12/1/98
3. Time of Deeth: 9:50 PM
4a. Facility Name (If not institution, give street end numbar): 3113 Garden Avenue
4b. City, Town, or Location of Death: Baltimore
4c. County of Deeth: Baltimore

Funeral Director

5. Sociel Security Number: 220-14-4869
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 74 Yrs. | If Under 1 Yaar: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Day, Year): 3/25/1924
9. Birthplece (State or Foraign Country): Maryland

Usuel Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3113 Garden Avenue
10f. Zip Code: 21234
10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Marriad 3☐ Widowed 4☐ Divorced
12. Was Decedant Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - Americen Indien, Black, White, etc. Specify: White

15. Decedent's Educetion (Specify only highest greda completed): Elementery/Secondery (0-12): 12 / College (1-4or 5+):
16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Fethar's Nama (First, Middle, Last): Albert F. Mitzel
18. Mother's Name (First, Middle, Maiden Surname): Anna Wachter

19e. Informent's Name/Relationship (Type, Print): Joseph Price Sr./Husband
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 3113 Garden Avenue Baltimore, Maryland 21234

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Moreland Memorial Park
Date: 12/5/98
20c. Location - City or Town, State: Baltimore, Maryland

21. Signeture of Funeral Service Licensee: ▶ Juanita R Thomas
22. Name and Address of Facility: John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206

Physician /Medical Examiner

23a. Pert I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only ona ceuse on each line.

Approximete Intervel Between Onset end Death

Immediate Cause (Final disease or condition resulting in deeth)
a. Respiratory failure
Due to (or as a consequence of):
b. CHF. COPD Hx CVA,
Sequantially list conditions, if eny, leading to immediata ceuse. Enter Underlying Cause (Disease or injury thet initiated events resulting in deeth) Lest
Dua to (or es e consequence of):
c. Cardiomyopathy. CAD, Asthma,
Dua to (or es e consequanca of):
d. NIDDM

Part II. **Other significent conditions** contributing to death but not resulting in tha underlying ceuse given In Part I.: Hyperlipidemia

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Wes en eutopsy performed? 1☐ Yas 2☒ No
24b. Were eutopsy findings availabla prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end place, end due to the ceuse(s) end menner es stated. 2☐ **Medical Examiner:** On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner stated.

29b. Signature end title of certifier: ▶ Noreen Iqbal Hashmi
29c. License number: D41635
29d. Date signed (Month, Dey, Year): 12.2.98

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print): Noreen Hashmi 9512 Harford Road Baltimore Mayland 21234

State Registrar

31. Date filed (Month, Dey, Year): DEC 04 1998
32. Registrar's Signature: ▶ [signature]

AP 6

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificete be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 37153

ITEMS: #18 PER F.H. G766 12-11-98 WR.

Certificate of Death

Reg. No.

DOROTHY ELIZABETH ROBERTS

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Dorothy Elizabeth Roberts

2. Dete of Deeth — Month: 11 Day: 23 Year: 1998

3. Time of Death: 10:30 AM

4a. Fecility Name *(If not institution, give street and number)*: Edenwald Retirement Center

4b. City, Town, or Location of Deeth: Towson

4c. County of Deeth: Baltimore Co.

Funeral Director

5. Sociel Security Number: 218-34-0282

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthdey)*: 87 Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Day, Yeer)*: May 15,1911

9. Birthplece *(Stete or Foreign Country)*: Baltimore, Md.

Usual Residence of Decedent

10a. Stete: Maryland

10b. County: Baltimore Co.

10c. City, Town or Location: Towson

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 800 Southerly Drive

10f. Zip Code: 21204

10g. Citizen of Whet Country?: United States

11. Meritel Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Yeer or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 1☐ Yes 2☒ No *Specify:*

14. Rece - Americen Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)* — Elementery/Secondery (0-12): 12 — College (1-4or 5+): n/a

16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Home Maker

16b. Kind of Business/Industry: Own Home

17. Fether's Neme *(First, Middle, Last)*: Frank Peissner

18. Mother's Neme *(First, Middle, Maiden Surname)*: Julia ELIZABETH BECKER

19a. Informent's Name/Reletionship *(Type, Print)*: Dr. Mark D. Roberts (Grandson)

19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1109 Dulaney Gate Circle Cockeysville, Md.21030

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Plece of Disposition *(Name of cemetery, cremetory or other piece)*: Parkwood Cemetery

Dete: 12/01/98

20c. Location - City or Town, Stete: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Jeffrey L. Gair — Jeffrey L. Gair

22. Neme end Address of Fecility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md.21204

Physician /Medical Examiner

23a. Pert. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one cause on eech line.

Approximete Interval Between Onset end Death

Immediete Ceuse (Final disease or condition resulting in deeth)

e. MYOCARDIAL INFRACTION — 1 HR

Due to (or es e consequence of):

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in deeth) Lest

b. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE — 20 YRS.

Due to (or es e consequence of):

c. PARKINSONS DISEASE — 15 YRS

Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveilable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Plece of Death *(Check only one)* — Hospital: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury *(Month, Day Yeer)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Deecribe how injury occurred

28e. Plece of Injury - At home, farm, street, fectory, offica building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, dete end place, end due to the cause(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end piece, end due to the cause(s) end menner stated.

29b. Signature end title of certifier: John Shavers

29c. License number: D27838

29d. Date signed *(Month, Day, Yeer)*: 12/24/98

30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print): John Shavers, M.D., 518 Camp Meade Rd., Linthicum, Md. 21090

State Registrar

31. Dete filed *(Month, Day, Yeer)*: DEC 04 1998

32. Registrer's Signeture: Penny G. Sparks

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours efter death with the Meryland Department of Heelth end Mentel Hygiene. **Important: If Item 27 is merked other than 'neturel', or Items 23a or 28a-f show any injury or other treumetic event, the Medicel Exeminer must be notified et once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the deeth certificate be executed within 24 hours efter death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 37154

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James Alexander Robertson
2. Date of Death (Month, Day, Year): November 28, 1998
3. Time of Death: 11:45pm
4a. Facility Name (If not institution, give street and number): Carroll County General Hospital
4b. City, Town, or Location of Death: Westminster
4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 215-34-3980
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 61 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan 29, 1937
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Glyndon
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 13913 Longnecker Road
10f. Zip Code: 21071
10g. Citizen of Whet Country?: USA

11. Meritel Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Detes:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - Americen Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12 | College (1-4or 5+): 5
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Banker
16b. Kind of Business/Industry: Banking

17. Fether's Neme (First, Middle, Last): Francis Herbert Robertson
18. Mother's Neme (First, Middle, Maiden Sumame): Myra Porter

19a. Informent's Neme/Reletionship (Type, Print): Alice Ann Robertson/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 13913 Longnecker Road, Glyndon, MD 21071

20a. Method of Disposition: 1 [ ] Buriel 2 [X] Cremetion 3 [ ] Removel from Stete 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Crematory Baltimore-Washington | Date: 11/30/98
20c. Location - City or Town, State: Laurel, Maryland

21. Signature of Funeral Service Licensee: Bryan W. Clary
22. Neme end Address of Facility: Lemmon Funeral Home, 10 W. Padonia Road, Timonium, MD 21093

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line. (Approximete Interval Between Onset end Death)

Immediate Cause (Finel disease or condition resulting in deeth):
a. Exsanguination
Due to (or es a consequence of):
b. Ruptured Abdominal Aortic Aneurysm 4hrs

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Disease or injury thet initiated events resulting in deeth) Last:
Due to (or as e consequence of):
c.
Due to (or as e consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.: Acute myocardial infarction

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings eveilable prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medicel examiner? 1 [X] Yes 2 [ ] No
26. Place of Deeth (Check only one): Hospitel: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Naturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined
28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the cause(s) end menner es steted. 2 [ ] Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and menner steted.

29b. Signeture end title of certifier: Robert Gordon
29c. License number: D0020554
29d. Date signed (Month, Day, Year): 11/29/98

30. Neme and eddress of person who completed cause of death (Item 23a) (Type, Print): Robert Gordon, M.D. 122 Slade Ave., suite 101, Baltimore, MD 21208

State Registrar

31. Dete filed (Month, Dey, Yeer): DEC 04 1998
32. Registrar's Signature: Brenda G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37155

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): JULIA RICH
2. Dete of Deeth: Month December, Dey 1, Year 1998
3. Time of Death: 4:00 pm
4a. Facility Neme (If not institution, give street end number): Maryland General Hospital
4b. City, Town, or Location of Death: Baltimore City
4c. County of Deeth: N/A

Funeral Director

5. Social Security Number: 224-30-0320
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 92 Yrs. — If Under 1 Yeer: Months / Deys; If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Dey, Yeer): 07/17/1906
9. Birthplece (State or Foreign Country): N. Carolina

Usual Residence of Decedent

10a. Stete: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street end Number: 328 N. CARROLLTON AVENUE
10f. Zip Code: 21223
10g. Citizen of Whet Country?: U.S.A.

11. Maritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Bleck, White, etc. Specify: Black
15. Decedent's Educetion (Specify only highest grade completed): Elemantary/Secondary (0-12): 6th; Collage (1-4or 5+):
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Laborer
16b. Kind of Business/Industry: Planter's Peanuts
17. Father's Name (First, Middle, Last): Edward Bush
18. Mother's Neme (First, Middle, Meiden Surneme): Annie Hardy
19a. Informant's Name/Relationship (Type, Print): Mary E. McCray
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 328 N. Carrollton Ave., Balto., MD 21223
20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other place): Western Star Cemetery — Date: 12/8/98
20c. Location - City or Town, State: Baltimore, MD
21. Signeture of Funeral Service Licensee: ▶ Leroy O. Dyett
22. Neme and Address of Feciility: LEROY O. DYETT & SON FUNERAL HOME, P.A. 4600 LIBERTY HEIGHTS AVE., BALTO, MD 21207

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failure. List only one cause on eech line. — Approximate Intervel Between Onset end Deeth

Immediate Ceuse (Finel disease or condition resulting in death): e. Respiratory Arrest
Due to (or as a consequence of):
Sequentially list conditions, if eny, leeding to immediate causa. Entar Underlying Cause (Diseesa or Injury that initieted events resulting in death) Last:
b. Chronic Obstructive Pulmonary Disease
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significent conditions** contributing to death but not resulting in the underlying ceusa given in Part I.: History of Colon Cancer, Dementia, Schizophrenic

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings eveileble prior to completion of cause of deeth? 1☐ Yes 2☑ No

25. Was cese referred to medicel examiner? 1☐ Yes 2☑ No

26. Plece of Deeth (Check only one): Hospitel: 1☑ Inpetient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Yeer)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, ferm, streat, fectory, office building, etc. (Spacify)
28f. Location (Streat and Number or Rural Route Number, City or Town, State)

29a. Certifiar (Check only one): 1☑ **Certifying Physician:** To tha best of my knowladga, deeth occurred at tha time, deta end place, and due to tha causa(s) and mennar as stated. 2☐ **Medical Examiner:** On tha basis of examination end/or investigation, in my opinion, deeth occurred at tha time, data and place, end due to tha ceusa(s) end manner stated.

29b. Signeture end title of certifier: ▶ Eglt MD.
29c. License number: P12671
29d. Date signed (Month, Dey, Yeer): 12/1/98

30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print): Elisa Gill, M.D. % Maryland General Hospital.

State Registrar

31. Date filed (Month, Day, Yeer): DEC 04 1998
32. Registrar's Signeture: Jennie G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Julia Rich

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: Tha law requires that tha death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by tha attending physician and completely filled in by tha funeral director, page 2 should be detached for use at the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37156

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOSEPH M. ROGGENKAMP
2. Data of Death — Month: NOVEMBER Day: 24 Year: 1998
3. Time of Death: 10:55 AM
4a. Facility Name (If not institution, give street and number): Johns Hopkins Bayview Medical center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 215 38 7673
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 78 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 14, 1920
9. Birthplace (State or Foreign Country): Connecticut

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Timonium
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 508 Limerick Circle, unit 303
10f. Zip Code: 21093
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: 1942-61
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 03
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Army Officer
16b. Kind of Business/Industry: Armed Forces
17. Father's Name (First, Middle, Last): Anthony Mathias Roggenkamp
18. Mother's Name (First, Middle, Maiden Surname): Irene Malette
19a. Informant's Name/Relationship (Type, Print): Dorcas T. Roggenkamp/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 508 Limerick Ct., Unit 303, Timonium, MD 21093
20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Crematory — Baltimore Washington — Date: 11/25/98
20c. Location - City or Town, State: Laurel, Maryland
21. Signature of Funeral Service Licensee: Bryan W. Clary
22. Name and Address of Facility: Lemmon Funeral Home, 10 W. Padonia Road, Timonium, MD 21093

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Cardiac Arrhythmia	seconds
Due to (or as a consequence of): b.	Metabolic and Respiratory Acidosis	hours
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	Cardiac Failure	days
Due to (or as a consequence of): d.	Septic Shock	days

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Restrictive Cardiomyopathy
Pulmonary Edema
Acute renal failure

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Ellen Li MD
29c. License number: ~~48040~~ P-12212
29d. Date signed (Month, Day, Year): November 24, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ellen Li, Johns Hopkins Bayview Medical center, 4940 Eastern Avenue, Baltimore, Maryland 21224

State Registrar

31. Date filed (Month, Day, Year): DEC 04 1998
32. Registrar's Signature: Geneva G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

P12212

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37157

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): WILLIAM F. ROSE JR.
2. Dete of Death Month: Nov Dey: 30 Year: 1998
3. Time of Death: 5:42 AM
4a. Facility Nama (If not institution, give street and numbar): BON SECOURS HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-58-5737
6. Sex: 1☑M 2☐F
7. Age (In yrs. last birthday): 48 Yrs. | If Under 1 Yaar: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Yeer): JULY 26, 1950
9. Birthplace (Stata or Foreign Country): MARYLAND

Usuel Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: BALTO. MD
10d. Inside City Limits: 1☐Yes 2☑No
10e. Street end Number: 7934 LANSDALE RD
10f. Zip Code: 21224
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Naver Marriad 2☐ Married 3☐ Widowed 4☑ Divorced
12. Was Decedent Ever in U,S. Armed Forces? 1☐ Yas 2☑ No If Yes, Give Yeer or Detes:
13. Was Decadant of Hispenic Origin? (Specify Yas or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grede completed): Elementery/Secondery (0-12): 9th | College (1-4or 5+): N/A
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT usa retired): GRAVE DIGGER
16b. Kind of Business/Industry: CEMETERY CO.

17. Fathar's Nama (First, Middla, Last): WILLIAM F. ROSE SR.
18. Mother's Name (First, Middla, Maiden Surneme): COLLEEN SLAGLE

19a. Informant's Name/Relationship (Type, Print): WILLIAM F. ROSE III
19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 7934 LANSDALE RD. BALTO. MD 21224

20a. Method of Disposition: 1☐ Burial 2☑ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other place): METRO CREMATORY.
Date: 12/2/98
20c. Location - City or Town, Stete: CATONSVILLE, MD.

21. Signature of Funerel Service Licensee: Frank J. DeLuca III
22. Name and Address of Facility: DELLA NOCE & SONS FUNERAL HOME 322 S. HIGH ST. BALTO. MD 21202.

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the deeth. Do not antar the mode of dying, such as cerdiac or raspiratory arrest, shock, or heart feilure. List only one ceuse on each line. — Approximate Interval Between Onset end Death

Immediate Cause (Finel disaese or condition resulting in deeth): e. PNEUMONIA

Due to (or es a consequence of):

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury thet initieted events resulting in deeth) Lest:
b. ACQUIRED IMMUNO DEFICIENCY SYNDROME
Due to (or es e consequence of):
c.
Dua to (or as a consequence of):
d.

Part II. **Other eignificent conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of deeth? 1☐ Yee 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Wara eutopsy findings available prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Was cese referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Hom 5☐ Residence 6☐ Other (Specify)
27. Menner of Deeth: 1☑ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Phyelcian:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner es steted. 2☐ **Medical Exeminer:** On the basis of examination end/or Investigetion, in my opinion, death occurred et the time, date and place, end due to the ceuse(s) and manner stated.

29b. Signature end titla of certifier: Rosita R. Cruz MD
29c. Licansa number: D0030355
29d. Data signed (Month, Day, Yaer): 11/30/98

30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print): ROSITA R. CRUZ M.D. BON SECOURS HOSPITAL

State Registrar

31. Dete filed (Month, Day, Yeer): DEC 04 1998
32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for usa as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37158

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): PAUL SAXON

2. Date of Death: Month 12 Day 2 Year 98

3. Time of Death: 8:30 A.M.

4a. Facility Name (If not institution, give street and number): BON SECOURS HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 214-28-4579

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 68 Yrs.

If Under 1 Year: Months ____ Days ____

If Under 24 Hrs.: Hours ____ Min. ____

8. Date of Birth (Month, Day, Year): NOV. 17, 1930

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10e. State: MARYLAND

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 2927 ARUNAH AVE

10f. Zip Code: 21216

10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: KOREAN CONFLICT

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 11TH GRADE

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CARPENTER

16b. Kind of Business/Industry: U.S. POSTAL SERVICE

17. Father's Name (First, Middle, Last): PAUL JOSEPH SAXON

18. Mother's Name (First, Middle, Maiden Surname): BESSIE TAYLOR

19a. Informant's Name/Relationship (Type, Print): MARY E. SAXON / WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2927 ARUNAH AVE BALTIMORE, MD 21216

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): LOUDON PARK CEMETERY

Date: 12/7/98

20c. Location - City or Town, State: BALTIMORE, MD

21. Signature of Funeral Service Licensee: Gray Harris

22. Name and Address of Facility: CHATHAM HARRIS F.H. 5240 REISTERSTOWN ROAD BALTIMORE, MD 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CARDIORESPIRATORY ARREST

Due to (or as a consequence of):

b. CORONARY ARTERY DISEASE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as e consequence of):

c. CANCER OF ESOPHAGUS

Due to (or as e consequence of):

d. CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed? 1 ☑ Yes 2 ☐ No

24b. Were autopsy findings eveilable prior to completion of cause of death? 1 ☑ Yes 2 ☐ No

25. Was case referred to medical exeminer? 1 ☐ Yes 2 ☒ No

26. Piece of Death (Check only one)

Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Deeth: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28e. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete and plece, end due to the ceuse(s) end menner es stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: WARREN SMITH MD

29c. License number: D24148

29d. Date signed (Month, Day, Year): 12-2-98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 3502 W. ROGERS AVE #6 BALT. MD 21215

State Registrar

31. Date filed (Month, Day, Year): DEC 04 1998

32. Registrar's Signature: Jennie D. Sparks

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that tha death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, pega 2 should be detached for use es the burial-transit permit. Pagas 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37159

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: William L. Sykes
2. Date of Death Month Day Year: December 1, 1998
3. Time of Death: 12:10 pm
4a. Facility Name *(If not institution, give street and number)*: Maryland General Hospital
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: NA

Funeral Director

5. Social Security Number: 218-30-6460
6. Sex: 1 ☒ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 61 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 04-16-37
9. Birthplace *(State or Foreign Country)*: NC

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 901 Chauncey Avenue
10f. Zip Code: 21217
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11th Grade; College (1-4 or 5+): NA
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Truck Driver
16b. Kind of Business/Industry: Van Line Company

17. Father's Name *(First, Middle, Last)*: Allen Sykes
18. Mother's Name *(First, Middle, Maiden Surname)*: Erma Brown

19a. Informant's Name/Relationship *(Type, Print)*: Raymond Sykes
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6737 Wilmont Drive Baltimore, Maryland 21207

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Greenmount Cemetery
Date: 12-05-98
20c. Location - City or Town, State: Baltimore, MD.

21. Signature of Funeral Service Licensee: Francis [illegible]
22. Name and Address of Facility: WM. C. March FH 1101 E. North Avenue Baltimore, Maryland 21202

Physician /Medical Examiner

23a. Part I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Bilateral Massive Pulmonary Thromboemboli

Due to (or as a consequence of): b. Arteriosclerotic Cardiovascular Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☑ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☑ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death *(Check only one)*: Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other *(Specify)*

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Jose Enrique L. Garcia
29c. License number: P12670
29d. Date signed *(Month, Day, Year)*: 12/3/98

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Jose Garcia, M.D. c/o Maryland General Hospital

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 04 1998
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

William Sykes.

WR 2

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

MEO

ITEMS: #17, 18, 25 PER F.H. G766 12-4-98 WR.

Reg. No. 98 37160

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Thomas L Scott

2. Date of Death: Month September, Day 25, Year 1998

3. Time of Death: 3:31 AM

4a. Facility Name (If not institution, give street and number): Baltimore VA Medical Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

Funeral Director

5. Social Security Number: 215-54-1354

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 47 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.

8. Date of Birth (Month, Day, Year): 7/1/1951

9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: Md

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 940 East Biddle St,

10f. Zip Code: 21202

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 1968-71

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Unk.

16b. Kind of Business/Industry: Unk

17. Father's Name (First, Middle, Last): ~~Jennette Cannon~~ UNKNOWN

18. Mother's Name (First, Middle, Maiden Surname): UNKNOWN

19a. Interment's Name/Relationship (Type, Print): Jennette Cannon Death's Clerk-V.A. Hospital

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): Medical Center 10 North Greene St 21201

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Garrison Forest VA

Date: 10/19/98

20c. Location - City or Town, State: Owings Mills MD

21. Signature of Funeral Service Licensee: L. Carroll

22. Name and Address of Facility: Irvin Carroll Funeral Home 1712 W. North Ave Balt. Md. 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Endocarditis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Aortic Insufficiency

Due to (or as a consequence of):

c. Sepsis

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☑ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Elizabeth Stoller MD

29c. License number: P10224

29d. Date signed (Month, Day, Year): September 25, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Elizabeth Stoller MD 22 S. Greene St. Baltimore, MD 20201

State Registrar

31. Date filed (Month, Day, Year): DEC 04 1998

32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 37161

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): KENNEDY SHAW
2. Date of Death (Month, Day, Year): DECEMBER 1 1998
3. Time of Death: 2:40pm
4a. Facility Name (If not institution, give street and number): UNIVERSITY OF MARYLAND MEDICAL SYSTEM
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: N/A
6. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthday): Yrs. — If Under 1 Year: Months — Days: 11 — If Under 24 Hrs.: Hours — Min.
8. Date of Birth (Month, Day, Year): 11 20 98
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md
10b. County: Baltimore
10c. City, Town or Location:
10d. Inside City Limits: 1☐ Yes 2☑ No
10e. Street and Number: 15 Walden Laurel Court
10f. Zip Code: 21207
10g. Citizen of What Country? USA

11. Marital Status: N/A — 1☐ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No — If Yes, give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12): N/A — College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): N/A
16b. Kind of Business/Industry: N/A

17. Father's Name (First, Middle, Last): Corey Shaw
18. Mother's Name (First, Middle, Maiden Surname): Nicole Dyson
19a. Informant's Name/Relationship (Type, Print): Nicole Dyson - Mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 15 Walden Laurel Ct. Baltimore, Md. 21207
20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): King Memorial Park — Date: 12-7-98
20c. Location - City or Town, State: Baltimore, Maryland
21. Signature of Funeral Service Licensee: J. Miller
22. Name and Address of Facility: Jeff Miller P.C. Funeral Home & Services 1639 N. Broadway, Balto. Md. 21213

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. MULTIORGAN SYSTEM FAILURE — 1 day
Due to (or as a consequence of):
b. DISSEMINATED HERPES — 5 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one) — Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Alice Ackerman
29c. License number: D 31670
29d. Date signed (Month, Day, Year): DECEMBER 1, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ALICE ACKERMAN, M.D. 22 SOUTH GREENE STREET BALTIMORE, MARYLAND 21201

State Registrar

31. Date filed (Month, Day, Year): DEC 04 1998
32. Registrar's Signature: G. Sparks

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use at the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 37162

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ALLEN ADALE Shaffer
2. Date of Death: Month NOV Day 30 Year 1998
3. Time of Death: 9 52 PM
4a. Facility Name (If not institution, give street and number): Washington County Hospital
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 215-94-6770
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 28 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 15, 1970
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Washington
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 10822 Downsville Pike
10f. Zip Code: 21740
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11th Grade; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Construction Worker
16b. Kind of Business/Industry: Water Welding Co.

17. Father's Name (First, Middle, Last): Ronald E. Shaffer, Jr.
18. Mother's Name (First, Middle, Maiden Surname): Linda Sue George

19a. Informant's Name/Relationship (Type, Print): Mrs. Linda Welch (mother)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8507 Castlemill Circle, Baltimore, MD 21236

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, cramatory or other place): Gardens of Faith Cem.
Data: 12/3/98
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Brian A. Willem
22. Name and Address of Facility: Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21236

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Asphyxiation
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

28. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [X] Sulcide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year): NOV 30, 98
28b. Time of Injury: 8:30 PM
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: HANGING
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): HOME
28f. Location (Street and Number or Rural Route Number, City or Town, State): 10822 Downsville Pike

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Deputy medical Examiner
29c. License number: OCME
29d. Date signed (Month, Day, Year): Dec 1, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ARTHUR H. HORN MD 818 VIRGINA AVE Hagerstown MD

State Registrar

31. Date filed (Month, Day, Year): DEC 04 1998
32. Registrar's Signature: [illegible] G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 37163

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Lottie Mary Stokes

2. Data of Daath — Month: NOVEMBER Dey: 30 Yaar: 1998

3. Tima of Deeth: 9:45 pm

4a. Facility Nama *(If not institution, giva street and number)*: DEATON UNIVERSITY OF MARYLAND MEDICINE

4b. City, Town, or Location of Daath: BALTIMORE CITY

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213-16-3574

6. Sax: 1☐ M 2☒ F

7. Aga *(In yrs. last birthday)*: 81 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Yaar)*: 02-25-1917

9. Birthplace *(Stata or Foreign Country)*: Phila, PA.

Usual Residence of Dacedant

10a. Stata: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore City

10d. Inside City Limits: 1☒ Yas 2☐ No

10a. Street end Number: 615 N. Carey Street

10f. Zip Coda: 21217

10g. Citizan of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedant Evar in U.S. Armed Forces? 1☐ Yas 2☒ No — If Yes, Giva Yaar or Datas:

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, atc. *Specify:* Black

15. Decedant's Educetion *(Specify only highast grada complatad)*: Elamentary/Secondary (0-12): 8th; Collega (1-4or 5+):

16a. Decedant's Usual Occupation *(Giva kind of work done during most of working lifa. DO NOT usa ratirad)*: Custodian

16b. Kind of Busnass/Industry: Public School System

17. Fathar's Name *(First, Middla, Last)*: Louis Henry Oliver

18. Mothar's Nama *(First, Middla, Maidan Surnama)*: Beulah A. Cotton

19a. Informant's Name/Ralationship *(Type, Print)*: Alice McCray/Sister

19b. Mailing Address *(Street and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda)*: 615 N. Carey Street, Baltimore, Maryland 21217

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Place of Disposition *(Nama of cematery, cramatory or othar placa)*: Baltimore Cemetery

Data: 12/7/98

20c. Location - City or Town, Stata: Baltimore, Maryland

21. Signatura of Funaral Service Licensaa: Charles H. Powell

22. Nama and Addrass of Facility: Wm O Bronor F/H 1206 W Northave

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complications that caused tha daath. Do not entar tha moda of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only one cause on aach lina.

		Approximate Interval Betwaan Onsat and Daath
Immediata Causa (Final disaasa or condition resulting in death) a.	ASPIRATION PNEUMONIA	4 Wks
Dua to (or as a consaquanca of): b.	CEREBRO VASCULAR ACCIDENT	10 Yrs
Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Disaasa or injury that initiatad events rasulting in death) Last — Dua to (or as a consaquanca of): c.	HYPERTENSION	30 Yrs
Dua to (or as a consaquanca of): d.	Chronic obstructive lung disease	10 Yrs

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying causa givan in Part I.

23b. Did tobacco usa contributa to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy parformad? 1☐ Yas 2☑ No

24b. Wara autopsy findings available prior to complation of ceuse of deeth? 1☐ Yas 2☐ No

25. Was cese refarrad to medical examinar? 1☐ Yas 2☑ No

26. Place of Deeth *(Chack only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Othar: 4☑ Nursing Home 5☐ Residance 6☐ Othar *(Specify)*

27. Manner of Daath: 1☑ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28a. Place of Injury - At homa, farm, street, factory, office building, atc. *(Specify)*

28f. Location *(Street and Numbar or Rural Routa Numbar, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowladge, daath occurred at the time, date end plece, end due to the ceuse(s) and menner es stetad. 2☐ **Medical Examinar:** On the basis of axamination and/or investigation, in my opinion, daath occurred at tha tima, data and place, end due to the cause(s) and manner stated.

29b. Signatura and title of certifiar: James P. G. Flynn MD

29c. Licansa number: D01346

29d. Data signed *(Month, Day, Yaar)*: DECEMBER 3 1998

30. Nama and addrass of parson who completed causa of daath (Item 23a) (Type, Print): JAMES P FLYNN MD DEATON SPECIALTY HOSPITAL & HOME 611 S CHARLES ST BALTIMORE MARYLAND 21230

State Registrar

31. Data filad *(Month, Day, Yaar)*: DEC 04 1998

Signatura: L. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with tha Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

LOTTIE MARY STOKES

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37164

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GARNETT L. SHAFER

2. Date of Death (Month, Day, Year): NOVEMBER 28, 1998

3. Time of Death: 11:20AM

4a. Facility Name (If not institution, give street and number): ANNE ARUNDEL GENERAL HOSPITAL

4b. City, Town, or Location of Death: ANNAPOLIS

4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 296-18-0188

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): AUG 20, 1924

9. Birthplace (State or Foreign Country): OHIO

Usual Residence of Decedent

10a. State: MD

10b. County: ANNE ARUNDEL

10c. City, Town or Location: ANNAPOLIS

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 735 SONNE DRIVE

10f. Zip Code: 21401

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indien, Black, White, etc. Specify: WHITE

15. Decedent's Educetion (Specify only highest grade completed): Elementary/Secondery (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SECRETARY

16b. Kind of Business/Industry: SKYWAYS, INC.

17. Father's Neme (First, Middle, Last): CHARLES DEAN

18. Mother's Name (First, Middle, Maiden Surname): CAROLINE CREDITT

19a. Informant's Name/Relationship (Type, Print): CHARLES SHAFER, SON

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 735 SONNE DRIVE, ANNAPOLIS, MD 21401

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): GLEN HAVEN MEMORIAL

Date: 12/2/98

20c. Location - City or Town, State: DONNELSVILLE, OHIO

21. Signeture of Funeral Service Licensee: Phillip Nash

22. Name and Address of Facility: STERLING-ASHTON-SCHWAB FUNERAL HOME, INC. 736 EDMONDSON AVENUE, BALTIMORE, MD 21228

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on eech line.

Approximete Intervet Between Onset and Death

Immediate Ceuse (Finel disease or condition resulting in death)

a. Pulmonary Edema -

Due to (or as a consequence of):

b. Severe Bilateral Pneumonia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Lest

Due to (or es a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobecco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Deeth (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Deeth: 1☑ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and menner stated.

29b. Signature and title of certifier: Ronald Sukow

29c. License number: D18480

29d. Date signed (Month, Day, Year): 11/28/98

30. Neme end address of person who completed cause of death (Item 23a) (Type, Print): 1684 V. Wings Green Crofton MD

State Registrar

31. Date filed (Month, Dey, Yeer): DEC 04 1998

32. Registrar's Signature: Jennie G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 37165

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Joseph Charles Schuman

2. Date of Death (Month, Day, Year): December 2, 1998

3. Time of Death: 10:30 am

4a. Facility Name (If not institution, give street and number): 17022 York Rd.

4b. City, Town, or Location of Death: Parkton

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 220 36 4290

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 58 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 25, 1940

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Parkton

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 17022 York Rd.

10f. Zip Code: 21120

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 11

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Tool & Die Maker

16b. Kind of Business/Industry: Steel & Wire Mfg.

17. Father's Nema (First, Middle, Last): Edward Schuman

18. Mother's Name (First, Middle, Maiden Surneme): Audrey Walters

19a. Informent's Neme/Reletionship (Type, Print): Bonita Schuman (Wife)

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 17022 York Rd. Parkton, Md. 21120

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removel from Stete 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Greenmount Crematory

Date: 12/5/1998

20c. Location - City or Town, Stete: Baltimore, Md.

21. Signature of Funeral Service Licensee:

22. Name and Address of Feciility: Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 21221

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

Approximete Interval Betwaan Onset end Death

Immediate Cause (Finel disease or condition resulting in death): e. GLIOBLASTOMA MULTIFORME — 1 YR

Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or es a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveilable prior to completion of cause of death? 1☐ Yes 2☒ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date and place, end due to the cause(s) end menner steted.

29b. Signature and title of certifier: MD

29c. License number: D18822

29d. Date signed (Month, Day, Year): 12/4/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): R. HABERSAT 111 MOUNT CARMEL ROAD PARKTON MD 21120

State Registrar

31. Date filed (Month, Day, Year): DEC 04 1998

32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use by the burial-transit case.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37166

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
MARY	HILDA	TOVEY	NOVEMBER 29, 1998	11:50 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
3008 EVERGREEN AVENUE	BALTIMORE CITY	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Dey, Yeer)	9. Birthplece (State or Foraign Country)
178-05-2875	1☐ M 2☒ F	82 Yrs.			1/20/16	PENNSYLVANIA

Usuel Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	N/A	Baltimore	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Coda	10g. Citizen of Whet Country?
3008 EVERGREEN AVENUE	21214	USA

11. Marital Status	12. Was Decedent Evar in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, atc.)	14. Race - American Indian, Bteck, White, etc.
1☐ Nevar Marriad 2☐ Married 3☒ Widowad 4☐ Divorced	1☐ Yes 2☒ No If Yas, Give Yaar or Datas:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usuel Occupation (Give kind of work dona during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondary (0-12)	College (1-4or 5+)		
12th GRADE		HOMEMAKER	OWN HOME

17. Father's Nama (First, Middle, Last)	18. Mothar's Neme (First, Middle, Meiden Surneme)
THOMAS PURCELL	MARTHA MADDEN

19a. Informent's Name/Reletionship (Type, Print)	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)
VINCE TOVEY SON	269 HOLLYWOOD BLVD. OXNARD, CA 93035

20a. Method of Disposition	20b. Ptece of Disposition (Neme of cemetery, cremetory or other piece)	Dete	20c. Location - City or Town, Stete
1☒ Burial 2☐ Cramation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	PARKWOOD CEMETERY	12/4/98	BALTIMORE, MD

21. Signature of Funeral Service Licensee ▶

22. Name and Address of Facility
THE JOHNSON FUNERAL HOME, P.A.
8521 LOCH RAVEN BLVD. TOWSON, MD 21286

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that causad the daath. Do not antar the moda of dying, such as cardiac or raspiratory arrast, shock, or heart teilure. List only one ceuse on eech line.

		Approximata Interval Between Onset end Death
Immediate Cause (Final disease or condition resulting in deeth)	e. Hypoxemic Encephalopathy	
	Due to (or es e consequence of):	
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest	b. Ventricular Arrythmia	
	Due to (or es e consequence of):	
	c. Ischemic Heart Diseuse	
	Due to (or es e consaquence of):	
	d.	

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Part I.

23b. Did tobecco use contribute to the cause of deeth? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed?	24b. Were autopsy findings aveilable prior to completion of cause of deeth?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical exeminer?	26. Ptece of Deeth (Check only one)	
1☐ Yes 2☒ No	Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Dete of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury et Work?	28d. Dascribe how injury occurred
1☒ Neturet 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one) 1☒ **Certifying Phyeicien**: To the best of my knowledge, deeth occurred et the time, dete end ptece, end due to the ceuse(s) end menner es steted.
2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the cause(s) and mannar stated.

29b. Signature and title of certifier	29c. License number	29d. Data signad (Month, Dey, Year)
▶ Ziad Mirza MD	D 41901	12-2-98

30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print)
3007 E Northern Parkway, Baltimore, MD 21214

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signatura
DEC 04 1998	Donna G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37167

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): QUINTIN GERALD WHITE
2. Date of Death: Month DEC. Day 3 Year 1998
3. Time of Death: 0514
4a. Facility Name (If not institution, give street and number): Sinai Hospital
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-76-9430
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 40 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): NOV. 22, 1958
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 4743 Park Heights Ave
10f. Zip Code: 21215
10g. Citizen of What Country? USA

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6th grade; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Maintenance Worker
16b. Kind of Business/Industry: Apartment Complex

17. Father's Name (First, Middle, Last): RICHARD WHITE
18. Mother's Name (First, Middle, Maiden Surname): Mary BRAXTON

19a. Informant's Name/Relationship (Type, Print): Mary White / MOTHER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21215: 4743 Park Heights Ave Baltimore, Md

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Western Star Cemetery | Date: 12-8-98
20c. Location - City or Town, State: Catonsville, Maryland

21. Signature of Funeral Service Licensee: Leroy Harris
22. Name and Address of Facility: CHATMAN - HARRIS 5340 Reisterstown Road Baltimore, Md 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. SEIZURE DISORDER
Due to (or as a consequence of):
b. ASPIRATION PNEUMONIA
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. END STAGE RENAL DISEASE
Due to (or as a consequence of):
d. AIDS

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
HEPATITIS C, ELECTROLYTE IMBALANCE, DRUG ABUSE

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: S. Bhatiani
29c. License number: D15300
29d. Date signed (Month, Day, Year): 12-3-98
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 6609 Reisterstown Rd Baltimore MD 21215 SWADESH BHATIANI

State Registrar

31. Date filed (Month, Day, Year): DEC 04 1998
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37168

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: RICHARD D. WILSON
2. Date of Death (Month, Day, Year): DECEMBER 3, 1998
3. Time of Death: 2:30 AM
4a. Facility Name *(If not institution, give street and number)*: 1108 RAMBLEWOOD RD. APT. E
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219 14 7347
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 70 Yrs. | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Yaar)*: April 4,1928
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. Stata: Maryland
10b. County: n/a
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1108 Ramblewood Rd., Apt.E
10f. Zip Code: 21239
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forcas? 1☒ Yas 2☐ No If Yas, Giva Yaar or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yas 2☒ No *Specify:*
14. Race - American Indian, Black, White, atc. *Specify:* White

15. Decedent's Education *(Specify only highast grade completed)*: Elementery/Secondary (0-12): 7 | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Painter
16b. Kind of Business/Industry: Building Construction

17. Fathar's Nama *(First, Middle, Last)*: (Unknown) Wilson
18. Mother's Name *(First, Middle, Maiden Surname)*: (Unknown)

19a. Informant's Name/Ralationship *(Type, Print)*: Jane Holloway / Personal Representative
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 100 D Cross Keys Rd., Baltimore, MD 21210

20a. Mathod of Disposition: 1☐ Burial 2☒ Cremation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*
20b. Place of Disposition *(Name of cematery, crematory or other piece)*: Green Mount Crematory | Data: 12/4/98
20c. Location - City or Town, Stata: Baltimore, MD

21. Signature of Funeral Service Licensee: Stephen D Lohrmann
22. Nama and Address of Facility: CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Dr., Baltimore, MD 21286

Physician /Medical Examiner

23a. Part1. Enter tha disaasa, or complications that causad tha daath. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or haart failura. List only ona causa on aach tina.

		Approximata Interval Between Onset and Death
Immediata Causa (Finat disaasa or condition resulting in death)	a. Cirrhosis	
	Due to (or as a consequence of):	
Sequantially list conditions, if any, laading to immadiata causa. Enter Underlying Ceuse (Disease or injury that initiated avants resulting in death) Last	b. Alcohol ABUSE	
	Dua to (or as a consequance of):	
	c.	
	Dua to (or as a consequance of):	
	d.	

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying cause given in Part I.

Depression
Congestive heart Failure
Esophageal varicies

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Ware autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was casa rafarrad to medical examinar? 1☐ Yas 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Neturel 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be datarmined
28a. Data of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, atc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifiar *(Check only one)*: 1☒ **Certifying Physician:** To tha best of my knowledga, death occurred at the tima, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner statad.

29b. Signatura and title of certifiar: Hilary Don md
29c. License number: D35102
29d. Data signed *(Month, Day, Year)*: 12.3.98

30. Name and address of person who complated causa of daath (Item 23a) (Type, Print): Hilary DON N.D. 3400 Brehms LANE Baltimore MD. 21213

State Registrar

31. Data filed *(Month, Day, Year)*: DEC 04 1998
32. Registrar's Signatura: Jennie G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that tha daath certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37169

Physician / Medical Examiner

1. Decedent's Name (First, Middle, Last): Lori T. Wholey

2. Date of Death (Month, Dey, Year): November 30, 1998

3. Time of Death: 1 20 A

4a. Facility Name (If not institution, give street end number): Levindale Hospital/Nursing Home

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 140-60-4718

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 39 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov. 30, 1959

9. Birthplace (State or Foreign Country): NY

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore Maryland

10d. Inside City Limits: x☒ 1 Yes 2☐ No

10e. Street end Number: 6230 Northwood Drive

10f. Zip Code: 21212

10g. Citizen of What Country: USA

11. Maritel Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Educetion (Specify only highest grede completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Nurse

16b. Kind of Business/Industry: Healthcare

17. Father's Name (First, Middle, Last): Jeremiah Joseph Wholey

18. Mother's Name (First, Middle, Maiden Surneme): Theresa Kivlehan

19a. Informent's Name/Relationship (Type, Print): Jean M. Butler / Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4040 Poplar Grove Dr. Vinton, VA 24179

20a. Method of Disposition: ☒ 1 Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Voshall Mem. Gardens

Date: Dec. 4, 1998

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Victor P. Doda, Jr.

22. Name end Address of Facility: Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore MD 21230

Physician / Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heert failure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in deeth)

a. Metastatic Breast Canen — 1995

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Last

b.

Due to (or es a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Wes cese referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one)

Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Phyaician:** To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end menner as steted. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: John Robert Thamer MD

29c. License number: D23767

29d. Date signed (Month, Day, Year): November 30, 1998

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): DEBRA S. WERTHEIMER MD, 2434 W. Belvedere Ave, Balto MD 21215

State Registrar

31. Dete filed (Month, Day, Year): DEC 04 1998

32. Registrar's Signature: D. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use in the burial-tranait

Lori Wholey

DHMH 16 Rev 6/95

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37170

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Dete of Deeth Month	Dey	Yeer	3. Time of Death
Barbara	Elizabeth	Ward	DECEMBER	02,	1998	9:13 PM

4e Feclity Neme (If not institution, give street and number)	4b. City, Town, or Location of Deeth	4c. County of Deeth
Saint Joseph Medical Center	Towson	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthdey)	If Under 1 Year Months	Deys	If Under 24 Hrs. Hours	Min.	8. Date of Birth (Month, Dey, Yeer)	9. Birthplace (State or Foreign Country)
218-28-5008	1☐ M 2☒ F	65 Yrs.					March 24, 1933	Maryland

Usuel Residence of Decedent

10e. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Baltimore	Lutherville	1☐ Yes 2☒ No

10e. Street end Number	10f. Zip Code	10g. Citizen of Whet Country?
4 Wendslow Place	21093	USA

11. Meritel Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Bleck, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☐ No If Yes, Give Year or Dates: X	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grede completed)		16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondary (0-12)	College (1-4or 5+)		
12		Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surneme)
Frank Novak, Jr.	Mildred Komendar

19a. Informent's Neme/Relationship (Type, Print)	19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code)
Mrs. Nancy Funkhouser/Daughter	319 Morning Dove Way Arnold, MD. 21012

20e. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)	Dulaney Valley Cemetery	12-7-98	Timonium, MD.

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name end Address of Feclity: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, MD. 21204

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

		Approximete Interval Between Onset end Deeth
Immediate Cause (Finel disease or condition resulting in death)	e. RESPIRATORY FAILURE	2 WEEKS
	Due to (or es e consequence of):	
	ASPIRATION PNEUMONIA	2 WEEKS
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Lest	b. Due to (or es e consequence of):	
	c. Due to (or es e consequence of):	
	d.	

Pert II. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Pert I.

23b. Did tobecco use contributa to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Wes en eutopsy performed?	24b. Were eutopsy findings available prior to completion of cause of deeth?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Wes case referred to medical examiner?	26. Plece of Deeth (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28e. Date of Injury (Month, Dey Yeer)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒ **Certifying Physicien:** To the best of my knowledge, death occurred et the time, dete end plece, end due to the cause(s) end menner es steted. 2☐ **Medical Examiner:** On the besis of examination end/or investigetion, in my opinion, death occurred et the time, dete end place, end due to the ceuse(s) end menner steted.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Yeer)
▶ [signature]	D30263	12-02-98

30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print): FRANCIS KHOO, M.D., 7620 YORK ROAD, TOWSON, MARYLAND 21204

State Registrar

31. Date filed (Month, Day, Year)	32. Registrer's Signeture
DEC 04 1998	▶ [signature]

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit permit.

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37171

Wagner, Elsie
Baltimore, Maryland 21215-0020

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Elsie M. Wagner
2. Date of Death (Month, Day, Year): NOVEMBER 30, 1998
3. Time of Death: 9:13PM
4a. Facility Name (If not institution, give street and number): GREATER BALTIMORE MEDICAL CENTER
4b. City, Town, or Location of Death: TOWSON
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 212-10-0458
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 96 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 14, 1902
9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Glen Arm
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 11630 Glen Arm Rd.
10f. Zip Code: 21057
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Chief Operator
16b. Kind of Business/Industry: Telephone Company

17. Father's Name (First, Middle, Last): William Parks
18. Mother's Name (First, Middle, Maiden Surname): Eva Jones

19a. Informant's Name/Relationship (Type, Print): Mr. David Lavin/Nephew
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3330 Fallston Rd. Fallston, Md. 21047

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Parkwood Cemetery | Date: 12-4-98
20c. Location - City or Town, Stete: Parkville, MD.

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, MD. 21204

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heert feilure. List only one cause on each line.

Approximete Interval Between Onset and Death

Immediate Cause (Final diseese or condition resulting in death): a. GASTROINTESTINAL HEMORRHAGE — 24 hrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

ATRIAL FIBRILLATION
CONGESTIVE HEART FAILURE
HYPERTENSION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Was cese referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature end title of certifier: ▶ M. Daly MD
29c. License number: D30433
29d. Date signed (Month, Dey, Year): 12/2/98

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): M. DALY MD 6701 N CHARLES ST. BALTIMORE MD 21204

State Registrar

31. Date filed (Month, Day, Year): DEC 04 1998
32. Registrer's Signature: ▶ per G. Sparks

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 37172

Certificate of Death

Reg. No.

Mary / Woods /

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Dete of Deeth Month	Dey	Year	3. Time of Deeth
Mary	E.	Woods	November	30	1998	3:54 P.M.

4e Feciity Name (If not institution, give street end number)	4b. City, Town, or Location of Death	4c. County of Deeth
Franklin Square Hospital Center	Rosedale	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Dey, Year)	9. Birthplace (Stete or Foreign Country)
215-03-6863	1☐ M 2☒ F	79 Yrs.					4-9-19	MD

Usuel Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Baltimore	Rosedale	1☐ Yes 2☒ No

10e. Street end Number	10f. Zip Code	10g. Citizen of Whet Country?
8042 Philadelphia Rd.	21237	USA

11. Marital Status	12. Was Decedent Ever In U.S. Armed Forces?	13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - Americen Indien, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Yeer or Detes:	1☐ Yes 2☒ No Specify:	Specify: white

15. Decedent's Eduction (Specify only highest grade completed)		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondery (0-12)	College (1-4or 5+)		
8	0	Factory Worker	Western Electric

17. Fether's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Bernard L. Gardiner	Frances Montgomery

19a. Informent's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code)
Walter P. Woods / husband	8042 Philadelphia Rd. Rosedale, MD 21237

20a. Method of Disposition	20b. Piece of Disposition (Neme of cemetery, cremetory or other place)	Dete	20c. Location - City or Town, Stete
1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donation 5☐ Other (Specify)	Gardens of Faith	12-4-98	Baltimore, MD

21. Signature of Funeral Service Licensee: Denise S. Kelly

22. Neme end Address of Feciity: Cvach/Rosedale Funeral Home, 1211 Chesaco Ave. Rosedale, MD 21237

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one ceuse on eech line.

		Approximete Intervel Between Onset and Death
Immediate Ceuse (Final disease or condition resulting in deeth)	a. Gastrointestinal Bleed	5 minutes
Due to (or es e consequence of):		
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest	b. Lung Cancer	1 month
Due to (or es e consequence of):		
	c.	
Due to (or as a consequence of):		
	d.	

Pert II. **Other significent conditions** contributing to deeth but not resulting in the underlying ceuse given in Pert I.

23b. Did tobacco uee contribute to the cauee of death? 1☒ Yee 2☐ No 3☐ Probably 4☐ Unknown

24a. Was en eutopsy performed?	24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Wes case referred to medical examiner?	26. Piece of Deeth (Check only one)	
1☐ Yes 2☒ No	Hospitel: 1☒ Inpetient 2☐ ER/Outpetient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth	28a. Dete of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end place, end due to the ceuse(s) end menner es steted.
2☐ **Medical Examiner:** On the besis of exemineticn end/or investigation, in my opinion, deeth occurred et the time, date and place, end due to the ceuse(s) and manner steted.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Brewster P.D.	RD 191783	11/30/98

30. Neme end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print)
Dr. Kevin Brewster 9000 Franklin Square Drive Baltimore Maryland 21237

State Registrar

31. Date filed (Month, Dey, Year)	32. Registrer's Signature
DEC 04 1998	B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylend Department of Health end Mentel Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use es the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

5 PEDS

DHMH 16 Rev 6/95

Amend: #5 Per Informant Film G766 12-29-98RC

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Item: #19b Per FH Film G766 12-4-98RC

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37173

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ODELLA WILLIAMS

2. Data of Death Month: DECEMBER Day: 2 Year: 1998

3. Time of Death: 5:00 AM

4a. Facility Name *(If not institution, give street and number)*: HARBOR HOSPITAL CENTER

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death:

Funeral Director

5. Social Security Number: 120-58-3556 (876-34-4826)

6. Sex: 1☐ M 2☑ F

7. Age *(In yrs. last birthday)*: 58 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: 1 18 40

9. Birthplace *(State or Foreign Country)*: New York, New York

Usual Residence of Decedent

10a. State: Md

10b. County: Baltimore

10c. City, Town or Location: Pikesville

10d. Inside City Limits: 1☐ Yes 2☑ No

10e. Street and Number: 7915-A Crisford Place

10f. Zip Code: 21208

10g. Citizen of What Country?: USA

11. Marital Status: 1☑ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 1☐ Yes 2☑ No *Specify:*

14. Race - American Indian, Black, White, atc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): | College (1-4or 5+): 4+

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Assitance Worker

16b. Kind of Businass/Industry: Baltimore Assitance Retared Children

17. Father's Name *(First, Middle, Last)*: UKN.

18. Mother's Nama *(First, Middle, Maiden Surname)*: Celia Williams

19a. Informant's Name/Relationship *(Type, Print)*: Tajina Williams - Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7915-A Crisford Place, ~~Pikesville~~ PIKESVILLE, Md. 21208

20a. Mathod of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from Stata 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mt. Holiness Cemetery | Data: 12-7-98

20c. Location - City or Town, Stata: Bulter, New Jersey

21. Signature of Funeral Service Licensee: PJ Miller

22. Nama and Address of Facility: Jeff Miller P.C. funeral Home & Services 1639 N. Broadway Balto. Md. 21213

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List *only* one cause *on* aach line.

		Approximata Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. UPPER GASTRO INTESTINAL BLEEDING	1 DAY
Due to (or as e consequence of):	CIRRHOSIS OF LIVER	2 MONTHS
Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. HEPATITIS C	2 MONTHS
Due to (or as a consequence of):	c.	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: ANEMIA

23b. Did tobacco use *contribute* to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of causa of death? 1☐ Yes 2☑ No

25. Was case refarred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Homa 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To tha best of my knowledge, death occurred at the tima, date and place, and due to tha causa(s) and mannar as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to tha cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: P 11939

29d. Data signed *(Month, Day, Year)*: DECEMBER 2, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BINDU GEORGE HARBOR HOSPITAL CENTER, 3001 S HANOVER STREET, BALTIMORE, MD 21225

State Registrar

31. Data filed *(Month, Day, Year)*: DEC 04 1998

32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item: #5 Per FH Film G766 12-11-98RC

Certificate of Death

Reg. No. 98 37174

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Clarence L. Wilson
2. Date of Death (Month, Dey, Yeer): December 2, 1998
3. Time of Death: 10:20 A.M.
4a. Facility Name (If not institution, give street end number): 3341 Elmora Avenue
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: ~~214-26-0294~~ 214-26-2302
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 68 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Year): Oct. 12, 1930
9. Birthplece (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street end Number: 3341 Elmora Avenue
10f. Zip Code: 21213
10g. Citizen of Whet Country?: U. S. A.

11. Maritel Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorcad
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Detes:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed): Elementery/Secondery (0-12): 10th Grade; College (1-4or 5+):
16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): President
16b. Kind of Business/Industry: Courier Service

17. Father's Name (First, Middle, Last): Albert Wilson
18. Mother's Name (First, Middle, Maiden Surneme): Esther Munchow

19a. Informent's Name/Reletionship (Type, Print): Charles D. Wilson (Son)
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 279 Black Oak Trail, Delta, Pennsylvania 17314

20a. Method of Disposition: 1 [X] Buriel 2 [ ] Cremetion 3 [ ] Removel from State 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Parkwood Cemetery
Date: 12/5/98
20c. Locetion - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Servica Licensee: ▶ Mark T. Zaragoza
22. Name end Address of Facility: Schimunek Funeral Home Inc. 3331 Brehms Lane, Baltimore, Maryland 21213

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one cause on eech line.

		Approximete Interval Between Onset end Deeth
Immediate Ceuse (Finel disease or condition resulting in deeth) e.	Myocardial Infarction	6 wks
Due to (or es e consequenca of):		
Sequentially list conditions, if eny, leading to immediete ceuse. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Lest b.	Coronary Atherosclerosis	40 yrs
Due to (or es e consequence of):		
c.		
Due to (or es e consequence of):		
d.		

Pert II. **Other significant conditiona** contributing to death but not resulting in the underlying cause given in Pert I.: Chronic obructive Lung Disease; Peripheral vascular Disease; Dementia

23b. **Did tobacco use contribute to the cauee of death?** 1 [X] **Yes** 2 [ ] **No** 3 [ ] **Probably** 4 [ ] **Unknown**

24a. Wes en eutopsy performed? 1 [X] Yes 2 [ ] No
24b. Were eutopsy findings aveileble prior to completion of cause of deeth? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Naturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner es steted. 2 [ ] **Medical Exeminer:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s) end manner stated.

29b. Signeture end title of certifier: ▶ Marc A. Mugnon MD
29c. License number: D17225
29d. Dete signed (Month, Dey, Year): 12-4-98

30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print): MARC A. MUGNON 200 E. 33rd St. Suite 631 Balt. MD 21218

State Registrar

31. Date filed (Month, Dey, Year): DEC 04 1998
32. Registrer's Signeture: Donna G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 37175

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Raymond L. Waters Jr.
2. Date of Death Month: 11 Dey: 28 Yeer: 1998
3. Time of Deeth: 3:50 Am
4e. Feclity Neme (If not institution, give street end number): 3603 Sylvan Drive
4b. City, Town, or Location of Deeth: Baltimore
4c. County of Deeth: NA

Funeral Director

5. Social Security Number: 216-07-4805
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. lest birthdey): 83 Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Yeer): 10-9-1915
9. Birthplace (State or Foreign Country): Md

Usual Residence of Decedent

10a. State: Md
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street end Number: 3603 Sylvan Drive
10f. Zip Code: 21207
10g. Citizen of Whet Country? U.S.A

11. Marital Status: 1 [ ] Never Merried 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grede completed): Elementary/Secondary (0-12): 12th grade; College (1-4or 5+): NA
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Self Employed
16b. Kind of Business/Industry: Frank Shoe Repair

17. Father's Neme (First, Middle, Lest): Raymond L. Waters, Sr
18. Mother's Name (First, Middle, Maiden Surname): Mary Helen Davis

19e. Informent's Name/Reletionship (Type, Print): Janet Bailey - Daughter
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 3603 Sylvan Drive Balto, Md 21207

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other piece): New Cathedral Cemetery
Date: 12-5-98
20c. Location - City or Town, State: Baltimore, Md

21. Signature of Funeral Service Licensee: John B. Johnson Jr.
22. Name and Address of Facility: March F.A. West 4300 Wabash Avenue Baltimore, Md 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line.

Approximete Interval Between Onset end Deeth

Immediate Ceuse (Final disease or condition resulting in death): e. HEPATIC CIRRHOSIS

Due to (or as e consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury thet initiated events resulting in deeth) Lest

b. Due to (or es e consequence of):

c. Due to (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical exeminer? 1 [ ] Yes 2 [X] No

26. Place of Deeth (Check only one): Hospital: 1 [ ] Inpetient 2 [ ] ER/Outpetient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Deeth: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Dete of Injury (Month, Dey Yeer)
28b. Time of Injury M
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the ceuse(s) end menner es steted. 2 [ ] Medical Examiner: On the basis of examination end/or investigetion, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end menner stated.

29b. Signature and title of certifier: M. Adkins
29c. License number: D52360
29d. Date signed (Month, Dey, Yeer): 11/30/98

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): KUBIK SANATH 1838 Greee Tree Rd Suite 300 Pikesville MD 21208

State Registrar

31. Dete filed (Month, Day, Yeer): DEC 04 1998
32. Registrer's Signature: B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
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10f1

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37176

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Annie B Wright

2. Date of Death — Month: November; Day: 30; Year: 1998

3. Time of Death: 0630

4a. Facility Name (If not institution, give street and number): Genesis Eldercare Multi-Medical Center

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 243-42-6981

6. Sex: 1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday): 71 Yrs.

If Under 1 Year — Months: ; Days:

If Under 24 Hrs. — Hours: ; Min.:

8. Date of Birth (Month, Day, Year): Jan. 12, 1927

9. Birthplace (State or Foreign Country): NC

Usual Residence of Decedent

10a. State: Md.

10b. County: n/a

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 3717 Springdale Avenue

10f. Zip Code: 21216

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th Grade

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Seamstress

16b. Kind of Business/Industry: self-employed

17. Father's Name (First, Middle, Last): Ozzie Belle

18. Mother's Name (First, Middle, Maiden Surname): unknown Anniemae

19a. Informant's Name/Relationship (Type, Print): Charles Wright son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 520 W. LaFayette Avenue Baltimore, Md. 21217

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Md. National Mem. Park

Date: Dec. 5

20c. Location - City or Town, State: Laurel, Md.

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Metastatic Breast Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Metastatic Cervical Cancer

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dementia

Decubitus Ulcer, Sacrum

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one) — Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D-24877

29d. Date signed (Month, Day, Year): 11/30/98

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Robert W. Antelman, MD 7141 Security Blvd, Baltimore, MD 21207

State Registrar

31. Date filed (Month, Day, Year): DEC 04 1998

32. Registrar's Signature: Geneva G. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that this death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37177

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Matthew Williams
2. Date of Death Month: Nov Day: 30 Year: 1998
3. Time of Death: 8:11 AM
4a. Facility Name *(If not institution, give street and number)*: Anne Arundel Medical Center
4b. City, Town, or Location of Death: Annapolis
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 130 46 3811
6. Sex: 1 ☒ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 44 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: June 8, 1954
9. Birthplace *(State or Foraign Country)*: Valley Stream N.Y.

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Gambrills
10d. Inside City Limits: 1 ☐ Yes 2 ☐ No XX
10e. Street and Number: 2035 Huntwood Drive
10f. Zip Code: 21054
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 XX Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XX No — If Yes, Give Yaar or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 XX No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Educetion *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 4
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Director
16b. Kind of Business/Industry: Computer Systems

17. Father's Name *(First, Middle, Last)*: Edward Williams
18. Mother's Name *(First, Middle, Maidan Surname)*: Margaret Regnier

19a. Informant's Name/Relationship *(Type, Print)*: Elisa Williams Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2035 Huntwood Drive Gambrills Maryland 21054

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Nama of cemetery, crematory or other place)*: The Huntt Crematory — Date: Dec. 5, 1998
20c. Location - City or Town, State: Waldorf Maryland

21. Signature of Funeral Service License: Todd Liller
22. Name and Address of Facility: Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disaasa or condition resulting in death): e. acute myocardial infarction — one hour

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest:

b. coronary artery disease

Due to (or as a consequence of):

c.

Dua to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco uae contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of ceuse of death? 1 ☐ Yes 2 ☐ No

25. Wes case referred to medicel examiner? 1 ☑ Yes 2 ☐ No

26. Piece of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicida 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Tima of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☐ **Certifying Physician:** To the best of *my* knowledge, death occurred at the time, date end place, and due to the cause(s) end menner as stated. 2 ☑ **Medical Examiner:** On the besis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and *manner* stated.

29b. Signature and title of certifier: Jeffrey Briggs MD
29c. License number: D28640
29d. Date signed *(Month, Day, Year)*: Nov 30, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): P.O. Box 28 Crownsville MD 21032

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 04 1998
32. Registrar's Signature: Penny G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours efter death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pega 2 should be detached for use es the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37178

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Jesse Carl Williams
2. Date of Death (Month, Day, Year): December 2, 1998
3. Time of Death: 2:50 PM
4a. Facility Name (If not institution, give street and number): Franklin Square Hospital Center
4b. City, Town, or Location of Death: Rossville
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 234 34 0259
6. Sex: 1 ☐ M 2 ☐ F — X
7. Age (In yrs. last birthday): 75 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 21, 1923
9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: White Marsh
10d. Inside City Limits: 1 ☐ Yes 2 ☐ No — X
10e. Street and Number: 5820 Pine Hill Drive
10f. Zip Code: 21162
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married — X 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No — X If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No — X Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): General Contractor
16b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): Alonzo Milton Williams
18. Mother's Neme (First, Middle, Maiden Surname): Rebecca Johnson

19a. Informant's Name/Relationship (Type, Print): Dana Williams (son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 52 Longeron Drive Middle River, Maryland 21220

20a. Method of Disposition: 1 ☒ Burial — X 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Bel Air Memorial Gardens
Date: 12/5/98
20c. Location - City or Town, State: Harford County, Md

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Bruzdzinski Funeral Home PA
1407 Old Eastern Avenue Essex, Maryland 21221

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. SQUAMOUS CELL LUNG CANCER — 1 yr

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or es a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
COPD
CORONARY ARTERY DISEASE

23b. Did tobacco use contribute to the cause of death? 1 ☒ Yes — X 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No — X
24b. Were autopsy findings eveilable prior to completion of ceuse of deeth? 1 ☐ Yes 2 ☐ No

25. Was cese referred to medicel examiner? 1 ☐ Yes 2 ☒ No — X

26. Place of Deeth (Check only one)
Hospital: 1 ☒ Inpatient — X 2 ☐ ER/Outpatient 3 ☐ DOA
Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural — X 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date end plece, end due to the ceuse(s) and menner as stated. — X
2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) end manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D31076
29d. Date signed (Month, Day, Year): 12/3/98

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): ORN ELIASSON 6830 HOSPITAL DR., BALTO. Md 21237

State Registrar

31. Date filed (Month, Day, Year): DEC 04 1998
32. Registrar's Signeture: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Peges 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 37179

Certificate of Death

Reg. No.

Wilkins, Robert

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Robert E. Wilkins
2. Date of Death: Month December, Day 2, Year 1998
3. Time of Death: 2:35 P.M.
4a. Facility Name (If not institution, give street and number): Franklin Square Hospital Center
4b. City, Town, or Location of Death: Rosedale
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 273 14 3203
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 75 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 30, 1923
9. Birthplace (State or Foreign Country): Ohio

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Middle River
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 6814 Columbia Rd.
10f. Zip Code: 21220
10g. Citizen of Whet Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Accounting Clerk
16b. Kind of Business/Industry: Railroad

17. Father's Name (First, Middle, Last): John Charles Wilkins Jr.
18. Mother's Name (First, Middle, Maiden Surname): Mabel Elizabeth Heiss

19a. Informent's Neme/Reletionship (Type, Print): Bruce Wilkins (Son)
19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 701 River Rd. Sykesville, Md. 21784

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Greenmount Crematory Date: 12/5/1998
20c. Locelion - City or Town, Stete: Baltimore, Md.

21. Signature of Funeral Service Licensee: John W. Burkowske
22. Neme and Address of Facility: Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 21221

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiec or respiratory errest, shock, or heart feilure. List only one cause on eech line.

		Approximete Interval Between Onset and Death
Immediate Cause (Finel diseese or condition resulting in deeth)	e. Atherosclerotic Heart Disease	3 MONTHS
Due to (or as a consequence of):		
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest	b.	
Due to (or es e consequence of):		
	c.	
Due to (or es e consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Emphysema

23b. Did tobacco uae contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner es stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end piece, and due to the ceuse(s) and manner steted.

29b. Signature end title of certifier: Steven Mason MD
29c. License number: D17348
29d. Date signed (Month, Dey, Year): December 2, 1998

30. Neme end eddress of person who completed cause of death (Item 23a) (Type, Print): DR Steven J. Mason 9101 Franklin Square Drive #104 Baltimore Maryland 21237

State Registrar

31. Dale filed (Month, Dey, Year): DEC 04 1998
32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 37180

Certificate of Death

Reg. No.

Caroline Watchman

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): CAROLINE JOSEPHINE WATCHMAN
2. Dete of Deeth Month/Dey/Yeer: December 1, 1998
3. Time of Death: 1:03 A.M.
4a. Fecility Neme (If not institution, give street end number): Franklin Square Hospital Center
4b. City, Town, or Location of Death: Rosedale
4c. County of Deeth: Baltimore

Funeral Director

5. Social Security Number: 213-03-8003
6. Sex: 1☐ M 2☑ F
7. Age (In yrs. lest birthday): 87 Yrs.
If Under 1 Year: Months / Deys
If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Dey, Yeer): Aug. 23, 1911
9. Birthplace (Stete or Foreign Country): Maryland

Usuel Residence of Decedent

10a. State: Maryland
10b. County: Baltimore City
10c. City, Town or Location: Baltimore City
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1904 E. Belvedere Ave.
10f. Zip Code: 21239
10g. Citizen of Whet Country?: USA

11. Meritel Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 yrs. College (1-4or 5+): 2 yrs.
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Secretary
16b. Kind of Business/Industry: G. M. Corp.

17. Fether's Neme (First, Middle, Last): William Wilson Watchman
18. Mother's Name (First, Middle, Maiden Surneme): Marie Auer

19a. Informent's Name/Reletionship (Type, Print): Mrs. Marie W. Grammer
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 7900 Babikow Rd. Baltimore, Md. 21237

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, crematory or other place): Loudon Park Cemetery
Dete: 12-3-1998
20c. Location - City or Town, Stete: Baltimore, Md.

21. Signeture of Funeral Service Licensee: Ronald C. Lassahn
22. Neme end Address of Fecility: Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236

Physician /Medical Examiner

23a. Pert I. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset end Death
Immediate Ceuse (Finel disease or condition resulting in deeth)	a. Acute Renal Failure	2 Days
Due to (or es e consequence of):		
Sequentially list conditions, if eny, leeding to immediete ceuse. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Lest	b. Myocardial Infarction	2 Days
Due to (or es e consequence of):		
	c. Coronary Artery Disease	
Due to (or es a consequence of):		
	d.	

Part II. **Other significant conditione** contributing to death but not resulting in the underlying cause given in Pert I.

Bilateral Lower Extremity Deep Venous Thrombosis, Gastrointestinal Bleeding, Hypertension, Chronic Renal Insufficiency

23b. Did tobacco use contribute to the cauee of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was en eutopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No
26. Plece of Death (Check only one): Hospitel: 1☒ Inpetient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Deeth: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Dete of Injury (Month, Dey Yeer)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physicien:** To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) and menner es steted. 2☐ **Medical Examiner:** On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) and menner steted.

29b. Signeture end title of certifier: M Hasser MD
29c. License number: D38754
29d. Date signed (Month, Dey, Year): December 1, 1998

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): Dr Malika Waseem 9000 Franklin Square Drive Baltimore, MD 21237

State Registrar

31. Dete filed (Month, Dey, Yeer): DEC 04 1998
32. Registrer's Signeture: Bonnie D. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use in the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Item: #24a,26 Per MEO Film G766 12-4-98RC

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

98 37181

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GEOFFREY JOHN WALTER

2. Date of Death — Month: NOV Dey: 3 Year: 1998

3. Time of Death: 1911

4a. Facility Name (If not institution, give street and number): 12 South WALNUT LANE

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

Funeral Director

5. Social Security Number: unknown

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 71 Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Year): Sept, 28 1927

9. Birthplece (State or Foreign Country): England

Usuel Residence of Decedent

10a. Stete: Maryland

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street end Number: 12 South Walnut Lane

10f. Zip Code: 21740

10g. Citizen of Whet Country?: unknown

11. Meritel Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:

14. Rece - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12): unknown — College (1-4or 5+): unknown

16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): unknown

16b. Kind of Business/Industry: unknown

17. Father's Neme (First, Middle, Last): unknown

18. Mother's Neme (First, Middle, Maiden Surname): unknown

19e. Informent's Name/Relationship (Type, Print): unknown

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): unknown

20e. Method of Disposition: 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☒ Donetion 5 ☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other place)

Date

20c. Location - City or Town, Stete

21. Signature of Fugeral Service Licensee: Joseph B. Van Sant

22. Name and Address of Facility: State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

Physician /Medical Examiner

23a. Part I. Enter the diseese, or compiications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one cause on each line.

Approximete Intervel Between Onset end Deeth

Immediate Ceuse (Finel diseese or condition resulting in deeth): e. Arthrosclatic CORONARY VASCULAR Disease

Due to (or es e consequenca of):

Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in death) Lest

b.

Due to (or es e consequence of):

c.

Due to (or es e consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uee contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24e. Wes en eutopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 1 ☐ Yes 2 ☐ No

25. Wes case referred to medical examiner? 1 ☒ Yes 2 ☐ No

28. Piece of Deeth (Check only one) — Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☒ Residenca 6 ☐ Other (Specify)

27. Menner of Death: 1 ☒ Neturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigetion 6 ☐ Could not be determined

28e. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, offica building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1 ☐ **Certifying Physician**: To the best of my knowledge, death occurred et the time, dete end plece, end due to the cause(s) end menner es steted. 2 ☒ **Medical Examiner**: On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end menner steted.

29b. Signature end title of certifier: Deputy medical Examiner

29c. License number: OCME

29d. Dete signed (Month, Dey, Year): NOV 3 1998

30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print): ARTHUR H. HORN MD 818 VIRGINIA AVE. Hagerstown MD

State Registrar

31. Dete filed (Month, Dey, Year): DEC 04 1998

32. Registrer's Signeture: Deputy B. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Gap 24a 26

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37182

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William Joseph Wagner
2. Date of Death (Month, Day, Year): 11/30/98
3. Time of Death: 10:30 AM
4a. Facility Name (If not institution, give street and number): 6920 Donachie Road Apt. 909
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212-12-4265
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 8/26/1921
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 6920 Donachie Road Apt. 909
10f. Zip Code: 21239
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Bank Manager
16b. Kind of Business/Industry: Bank

17. Father's Name (First, Middle, Last): Henry J. Wagner
18. Mother's Name (First, Middle, Maiden Surname): Tini Stipek

19a. Informant's Name/Relationship (Type, Print): Mary G. Prasch
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1205 Apparition Lane Baltimore, Maryland 21220

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Parkwood Cemetery
Date: 12/4/98
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Juanita R Thomas
22. Name and Address of Facility: John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. PROBABLE MYOCARDIAL INFARCTION — MINUTES
Due to (or as a consequence of):
b. HYPERTENSION
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. CHRONIC ATRIAL FIBRILLATION
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and mannar stated.

29b. Signature and title of certifier: James Ebeling MD
29c. License number: D34827
29d. Date signed (Month, Day, Year): 11/30/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JAMES EBELING MD 7401 OSLER DR. SUITE 202 TOWSON MD 21204

State Registrar

31. Date filed (Month, Day, Year): DEC 04 1998
32. Registrar's Signature:

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37183

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Roxie Adams

2. Date of Death: Month November Day 7 Year 1998

3. Time of Death: 8:16 pm

4a. Facility Name (If not institution, give street and number): Washington Adventist Hospital

4b. City, Town, or Location of Death: Takoma

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 268-24-1326

6. Sex: 1☐ M 2☒ F

7. Age (in yrs. last birthday): 95 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 7-30-03

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: MD

10b. County: Montgomery

10c. City, Town or Location: Takoma

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 49 Jefferson Ave.

10f. Zip Code: 20912

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Private

17. Father's Name (First, Middle, Last): William Hubbard

18. Mother's Name (First, Middle, Maiden Surname): Lilly

19a. Informant's Name/Relationship (Type, Print): James P. Adams - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 49 Jefferson Ave., Takoma, MD. 20912

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Glenwood

Date: 11/13/98

20c. Location - City or Town, State: Washington, DC

21. Signature of Funeral Service Licensee: R N Horton

22. Name and Address of Facility: R.N. Horton Co. Morticians, Inc. 600 Kennedy St. N.W. Washington, DC

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cardiac Arrest — immediate

Due to (or as a consequence of):
b. Hyponatremia — 72 hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Head trauma — 9 days

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Aortic Stenosis

Pace Maker for arrythmia

Atherosclerotic heart disease

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D 52481

29d. Date signed (Month, Day, Year): November, 8, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David Plotkin M.D. 11120 New Hampshire Avenue, Silver Spring MD 20904

State Registrar

31. Date filed (Month, Day, Year): NOV 17 1998

32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

ADH
98-6483-031
KAYLA ADAMS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 37184

ITEMS: #23 PART1 27 PER MEO G766 12-11-98 WR.

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
KAYLA M. ADAMS	NOVEMBER 7, 1998	2331 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
WASHINGTON ADVENTIST HOSPITAL	TAKOMA PARK	MONTGOMERY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Yaar		If Under 24 Hrs.		8. Data of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
			Months	Days	Hours	Min.		
NA	1☐ M X☐ F	Yrs.	1				OCT. 7, 1998	WASHINGTON, DC

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	MONTGOMERY	TAKOMA	X☐ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
123 Lee Ave., #302	20912	USA

11. Marital Status	12. Was Dacedant Evar in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - Americen Indian, Black, White, etc.
1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	1☐ Yas 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: BLACK

15. Decedent's Educetion (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
0			

17. Fathar's Neme (First, Middle, Last)	18. Mothar's Nama (First, Middle, Maiden Surnama)
Kevin Adams	Latonia Watson

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Straet and Number or Rural Route Number, City or Town, Stata, Zip Code)
Latonia M. Adams - Mother	123 Lee Ave., #302 Takoma, MD 20912

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from Stata 4☐ Donation 5☐ Other (Specify)	Parklawn Memorial Park	11/14/98	Wheaton, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ R.N. Horton	R.N. Horton co. Morticians, Inc. 600 Kennedy St., NW Washington, DC 20011

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not anter tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disaasa or condition resulting in death)
a. NEONATAL HEPATITIS (GIANT CELL HEPATITIS)

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Dua to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of deeth?
1☒ Yes 2☐ No	1☒ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒ Yes 2☐ No	Hospital: 1☐ Inpatiant 2☒ ER/Outpatient 3☐ DOA	Othar: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Deeth	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending Investigation 6☐ Could not ba determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) end menner as steted.
2☒ **Medical Examiner:** On the basis of examination and/or investigetion, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ J. Aaron Locke, MD	OCME	NOVEMBER 8, 1998

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)
J. Aaron Locke, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 17 1998	Penny G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 37185

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month / Day / Year	3. Time of Death
Sophia	Amass	November 11, 1998	8:25 P.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
4215 Fords Lane	Baltimore City	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
103-07-0729	1☐ M 2☒ F	98 Yrs.			APRIL 6, 1900	RUSSIA

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND		BALTIMORE	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
4215 FORDS LANE	21215	UNITED STATES

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates: X	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		HOMEMAKER	OWN HOME

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
"UNKNOWN"	SARA BORGAN

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
JANET AMASS (GRANDDAUGHTER)	15408 ROWLAND AVENUE - SILVER SPRING, MARYLAND 20905

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)	HEBREW FRIENDSHIP CEM.	11/15/98	BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
	EDWARD SAGEL FUNERAL DIRECTION 1091 ROCKVILLE PIKE - ROCKVILLE, MARYLAND 20852

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. ASCVD	5 year.
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last	b.	
Due to (or as a consequence of):		
	c.	
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

COPD

23b. **Did tobacco use contribute to the cause of death?** 1☐ **Yes** 2☑ **No** 3☐ **Probably** 4☐ **Unknown**

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☑ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☑ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Samuel T. Benn, MD	D16941	11/14/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Samuel T. Benesh, M.D.
21 Crossroads Dr. Owings Mills, md 21117

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 16 1998	B. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 37186

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
Evelyn Marie Birkett	NOVEMBER 18, 1998	0405

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
PENINSULA REGIONAL MEDICAL CENTER	SALISBURY	WICOMICO

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
529-24-1516	1☐ M 2☒ F	91 Yrs.			9/30/1907	Pennsylvania

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Worcester	Pocomoke City	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
13 Front Street	21851	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	1	management	child care

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Howard Bell Hunter	Ottilia Stein

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Curt Lippoldt (son)	13 Front St., Pocomoke City, MD 21851

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Salisbury Crematory	11/19/98	Salisbury, Maryland

21. Signature of Funeral Service Licensee: Michael A Dean M01129

22. Name and Address of Facility: Holloway-Melson Funeral Home, P.A. 103 Linden Ave., Pocomoke City, MD 21851

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Arteriosclerotic Heart Disease	30 years
Due to (or as a consequence of):	b. Arteriosclerosis	50 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Atrial Fibrillation, Sepsis Multiple Decubitus ulcer, sacral and feet

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
T. Evangelista MD	D37670	11/18/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. T. N. Evangelista, 105 Pine Bluff Road #4, Salisbury, MD 21801

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 20 1998	G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Evelyn M. Burkett 529-24-1516

12

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37187

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): OLGA LOUISE BUCKINGHAM

2. Date of Death (Month, Day, Year): NOVEMBER 21 1998

3. Time of Death: 12:55 PM

4a. Facility Name (If not institution, give street and number): Berlin Nursing and Rehabilitation Center

4b. City, Town, or Location of Death: Berlin

4c. County of Death: Worcester

Funeral Director

5. Social Security Number: 579-10-0066

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 95 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 4/29/03

9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: MD

10b. County: Worcester

10c. City, Town or Location: Berlin

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 409 West St.

10f. Zip Code: 21811

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elamantary/Secondary (0-12):

Collaga (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Personnel Director

16b. Kind of Business/Industry: Newspaper

17. Father's Name (First, Middle, Lest): Edwin Lamasure

18. Mother's Name (First, Middle, Maiden Surname): Bertha Sterns

19a. Informant's Name/Reletionship (Type, Print): Kenneth Buckingham/ Son

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 409 West St. Berlin, MD 21811

20a. Mathod of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other plece): Cape Henlopen Crematory

Date: 11/23/98

20c. Location - City or Town, Stete: Frankford, DE

21. Signature of Funeral Service Licensee: N. Kirk Burbage

22. Name end Address of Facility: Burbage Funeral Home, 108 William St. Berlin, MD 21811

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heert failure. List only one ceuse on each line.

Approximate Interval Between Onset end Death

Immediete Ceuse (Final disease or condition resulting in daath)

a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or es e consequenca of):

Sequantially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseasa or Injury thet initieted events resulting in deeth) Lest

b. ANEMIA

Due to (or es e consequenca of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significent conditions** contributing to death but not resulting in the undarlying cause givan in Part I.

23b. **Did tobacco use contribute to tha cause of death?** 1☐ **Yes** 2☐ **No** 3☐ **Probably** 4☐ **Unknown**

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Wara eutopsy findings eveilable prior to completion of cause of deeth? 1☐ Yes 2☒ No

25. Was case raferred to medical examiner? 1☐ Yes 2☒ No

26. Plece of Death (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Sulcide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Dascribe how injury occurred

28e. Placa of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, daath occurred at the time, date end plece, end due to tha cause(s) end mannar as stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigetion, in my opinion, deeth occurred at the time, data and place, end due to the ceusa(s) end mannar stated.

29b. Signature and title of certifier: E. Castaneda, MD

29c. License number: D46257

29d. Date signed (Month, Day, Year): 11/23/98

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print): EDWIN CASTANEDA, MD 9714 HEALTHWAY DRIVE BERLIN MD 21811 410-641-0646

2

State Registrar

31. Date filed (Month, Day, Yeer): NOV 23 1998

32. Registrer's Signeture: Donna B. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 37100

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Evelyn G. Brown

2. Date of Death Month Dey Year: NOVEMBER 18 1998

3. Time of Deeth: 8:47 PM

4e. Feclity Name (If not institution, give street end number): Doctors Hospital

4b. City, Town, or Location of Deeth: Lanham, Maryland

4c. County of Deeth: Prince Georges

Funeral Director

5. Social Security Number: 218-24-3232

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 70 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Yeer): Febuary 18/28

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince Georges

10c. City, Town or Location: Upper Marlboro

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 11453 Duley Station Rd

10f. Zip Code: 20772

10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indien, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grede completed): Elementery/Secondary (0-12): 12 / College (1-4or 5+):

16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Domestic

17. Father's Neme (First, Middle, Last): Robert Gordon

18. Mother's Name (First, Middle, Maiden Surneme): Margaree Simmons

19a. Informent's Neme/Relationship (Type, Print): John Brown/ Husband

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 11453 Duley Station Rd, Upper Marlboro MD 20772

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other place): Cedar Hill Cem. Date: Nov. 24, 98

20c. Location - City or Town, State: Suitland, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name end Address of Fecility: Adams Funeral Home, P.A. Aquasco, MD 20608

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

EVELYN G BROWN

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or hean failure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Death

Immediate Ceuse (Final disease or condition resulting in death)

e. MULTI-ORGAN FAILURE — 14 days

Due to (or es e consequence of):

b. SEPTIC SHOCK — 18 days

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last

Due to (or as e consequence of):

c. RUPTURED GANGRENOUS COLON — 18 days

Due to (or as e consequence of):

d. MESENTERIC VASCULAR OCCLUSION — 18 days

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

SEVERE GENERALIZED OCCLUSIVE ARTERIO-SCLEROTIC VASCULAR DISEASE

HYPERTENSION & DIABETES MELLITUS 1

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one): Hospital: 1☒ Inpetient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Yeer)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1☒ **Certifying Physicien:** To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) and menner es steted. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, dete end place, end due to the ceuse(s) and manner stated.

29b. Signature end title of certifier: [signature] MD - ATTENDING

29c. License number: D16197

29d. Date signed (Month, Dey, Yeer): 11-18-98

30. Nam end eddress of person who completed cause of deeth (Item 23e) (Type, Print): ANDRES C. LARA, MD - 9336 LANHAM-SEVERN RD. LANHAM, MD 20706

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Yeer): NOV 25 1998

32. Registrer's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37189

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): TOMMIE JAMES BOLER JR
2. Date of Death Month Day Year: NOV 12 1998
3. Time of Death: 5:44 PM
4e. Facility Name (If not institution, give street and number): NATIONAL NAVAL MEDICAL CENTER
4b. City, Town, or Location of Death: BETHESDA
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 374 68 2521
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 38 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): OCT 23 1960
9. Birthplace (State or Foreign Country): MICHIGAN

Usual Residence of Decedent

10a. State: VA.
10b. County: PRINCE WILLIAM
10c. City, Town or Location: WOODBRIDGE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 14145 GRAYSON ROAD
10f. Zip Code: 22191
10g. Citizen of Whet Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorcad
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Raca - American Indian, Bleck, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12 / College (1-4or 5+):
16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): SIGNALMAN
16b. Kind of Business/Industry: U.S. NAVY

17. Father's Name (First, Middle, Last): TOMMIE J. BOLER SR.
18. Mother's Name (First, Middle, Maiden Surname): BENNIE GLEATON

19a. Informant's Name/Relationship (Type, Print): CRYSTAL BOLER/WIFE
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 14145 GRAYSON RD. WOODBRIDGE, VA. 22191

20a. Method of Disposition: 1☒ Buriel 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): QUANTICO NAT. CEM.
Date: 11/19/98
20c. Location - City or Town, Stete: TRIANGLE VA.

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: WATSON F. H.INC. 3435 14th ST. N.W. 20010

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Meryland Department of Health and Mentel Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Blue

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or compilications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximete Intervel Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in deeth)
a. PNEUMOTHORAX
Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequenca of):
d.

Part II. **Other signifícant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uee contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an eutopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other (Specify)

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the besis of examination and/or investigation, in my opinion, deeth occurred at the time, dete end place, end due to the cause(s) end manner stated.

29b. Signature and title of certifier: ▶ [signature] M.D LT USNR
29c. License number: 8294 (MT)
29d. Date signed (Month, Day, Year): 13 Nov 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JEFFREY TJADEN, LT, MC, USNR
NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

10

State Registrar

31. Date filed (Month, Day, Year): NOV 18 1998
32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37190

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Arthur Anthony Bykowski
2. Date of Death (Month / Day / Year): November 13, 1998
3. Time of Death: 9:22 AM
4a. Facility Name *(If not institution, give street and number)*: 13109 Oriole Drive
4b. City, Town, or Location of Death: Beltsville
4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 187-26-4050
6. Sex: 1 ☒ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 62 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: April 11, 1936
9. Birthplaca *(Stata or Foraign Country)*: Pennsylvania

Usual Residence of Decedent

10a. Stata: MD
10b. County: Worchester
10c. City, Town or Location: Berlin
10d. Insida City Limits: 1 ☐ Yas 2 ☒ No
10e. Street and Number: 26 Lookout Point
10f. Zip Code: 21811
10g. Citizen of What Country?: USA
11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 1955-59
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, atc.): 1 ☐ Yes 2 ☒ No *Specify:*
14. Race - Amarican Indian, Black, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Giva kind of work done during most of working life. DO NOT use retired)*: Firefighter
16b. Kind of Business/Industry: District Government
17. Father's Nama *(First, Middle, Last)*: Stephen Thomas Bykowski
18. Mother's Name *(First, Middle, Maiden Surname)*: Anna Mary Petulski
19a. Informant's Name/Relationship *(Type, Print)*: Ann Randall Bykowski (wife)
19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: 13109 Oriole Drive, Beltsville, MD 20704
20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cematary, crematory or other piece)*: Gate of Heaven Cemetery — Data: 11/17/98
20c. Location - City or Town, State: Silver Spring, MD
21. Signature of Funeral Service Licensee: J. Kevin Gutowski
22. Nama and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not entar the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failura. List only one cause on eech tine.

		Approximata Intarval Batween Onsat and Death
Immediata Cause (Final disease or condition resulting in death) a.	Metastatic Pancreatic Cancer	1 year
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.		
	Due to (or as a consequence of):	
c.		
	Due to (or as a consequence of):	
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceusa given in Part I.

23b. Did tobacco use contributa to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Wara autopsy findings availabla prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case refarred to medicat examiner? 1 ☐ Yes 2 ☒ No

26. Placa of Death *(Check only ona)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Homa 5 ☐ Rasidanca 6 ☒ Othar *(Specify)* Wife's residence

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be datarmined

28a. Date of Injury *(Month, Day Year)*
28b. Tima of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At homa, farm, street, factory, office building, atc. *(Specify)*
28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To tha best of my knowledge, death occurred at the time, data and place, and dua to the causa(s) and mannar as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at tha tima, date and place, and due to tha cause(s) and manner stated.

29b. Signature and title of certifier: Clara Chan M.D.
29c. License number: D41828
29d. Data signed *(Month, Day, Year)*: November 13, 1998

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): Clara Chan, M.D. 7525 Greenway Center Drive, Greenbelt, MD 20770

State Registrar

31. Data filed *(Month, Day, Year)*: NOV 16 1998
32. Registrar's Signatura: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amend #17, 11/19/98, BMW, Montg.Co.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37191

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
MARILYN JOHNSON BURKART	NOVEMBER 10, 1998	7:30 P.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
6108 GRANBY ROAD BRIAR MEADOWS ASSISTED LIVING	DERWOOD	MONTGOMERY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
264-96-3961	1☐ M 2☒ F	72 Yrs.			Oct. 27, 1926	Illinois

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Florida	Lake	Mt. Dora	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of Whet Country?
1505 W. Heim Road	32757	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Merried 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grede completed)		16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	2	Housewife	Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surneme)
~~John Burkart~~ Armer Johnson	Mary Louise Lewis

19a. Informant's Name/Reletionship (Type, Print)	19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)
John Burkart, Son	18901 Muncaster Road, Derwood, Maryland 20855

20a. Method of Disposition	20b. Place of Disposition (Neme of cemetery, cremetory or other place)	Dete	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Metropolitan Crematory	Nov 12, 1998	Alexandria, Virginia

21. Signature of Funeral Service Licensee	22. Name end Address of Fecility
▶ [signature]	DeVol Funeral Home 10 E. Deer Park Drive, Gaithersburg, MD 20877

Physician /Medical Examiner

23a. Part I/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on eech line.

		Approximete Interval Between Onset end Deth
Immediate Cause (Finel disease or condition resulting in death)	a. Metastatic Breast Cancer	11/10/98
	Due to (or es e consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last	b.	
	Due to (or es a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditiona** contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. Did tobacco use contribute to the cause of death?	24a. Was en eutopsy performed?	24b. Were eutopsy findings avallable prior to completion of ceuse of deeth?
1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown	1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was cese referred to medical examiner?	26. Plece of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 8☒ Other (Specify) Assisted Living

27. Manner of Deeth	28a. Dete of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one)
1☒ **Certifying Phyalcian:** To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) end manner es steted.
2☐ **Medical Examiner:** On the besis of examinetion end/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)
▶ [signature]	365-06-2780	NOVEMBER 12, 1998

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)
THOMAS, REBECCA NATIONAL NAVAL MEDICAL CENTER, BETHESDA, MD

State Registrar

31. Dete filed (Month, Day, Year)	32. Registrar's Signeture
NOV 16 1998	[signature] G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 37192

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JACOB BRAUN
2. Date of Death (Month, Day, Yeer): November 17, 1998
3. Time of Death: 5:00 AM
4a. Facility Name (If not institution, giva street and numbar): 14409 Barkwood Drive
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 142-28-9332
6. Sex: 1☒M 2☐F
7. Age (In yrs. last birthday): 62 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 5, 1936
9. Birthplace (State or Foraign Country): Vineland, NJ

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 14409 Barkwood Drive
10f. Zip Code: 20853
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒No Spacify:
14. Race - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Eduction (Spacify only highast grada compiatad): Elementary/Secondary (0-12): — College (1-4or 5+): 5 Years
16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired): Electrical Engineer
16b. Kind of Business/Industry: Applied Physics Lab At Johns Hopkins University

17. Father's Name (First, Middla, Last): Benjamin Braun
18. Mother's Name (First, Middle, Maidan Surname): Lillian Greenblutt

19a. Informant's Name/Relationship (Type, Print): Wilma Braun, Wife
19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Steta, Zip Code): 14409 Barkwood Drive, Rockville, Maryland 20853

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Nama of cematary, cramatory or othar place): Judean Memorial Gardens — Date: 11/19/1998
20c. Location - City or Town, State: Olney, Maryland

21. Signature of Funeral Service Licensee: William A. Halyo
22. Name and Address of Facility: IVES-PEARSON FUNERAL HOME 2847 WILSON BLVD., ARLINGTON, VIRGINIA 22201

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pagas 1 and 2 should be filled within 72 hours after death with the Maryland Department of Haalth and Mantal Hygiene. **Important: If item 27 is marked other than 'natural', or itams 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: Tha law requires that the death cartificate be axecuted within 24 hours after death.
To the Funeral Director: Aftar this cartificata has been signed by tha attending physician and completaly filled in by tha funaral director, pagas 2 should ba datachad for use as tha burial-transit

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Intervel Between Onset end Death

Immediate Cause (Final disease or condition resulting in death): a. ANAPLASTIC ASTROCYTOMA — 22 MONTHS

Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initieted events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco uae contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☑ No

25. Was case referred to medicel examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only ona): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Routa Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end menner es stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: Joseph M. Haggerty MD
29c. License number: D32407
29d. Date signed (Month, Day, Year): November 18, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph M. Haggerty, M.D., 9707 Medical Center Drive, #300, Rockville, MD 20850

State Registrar

31. Date filed (Month, Day, Year): NOV 19 1998
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

98-6544-031
AARON JOSHUA M. BRIONES
ASP

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEMS: #24a,b, per Meo G766 12-22-98 WR.

Certificate of Death

98 37193
Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Aaron Joshua M. Briones
2. Date of Death Month/Day/Year: NOVEMBER 10 1998
3. Time of Death: 2236 P
4a Facility Name *(If not institution, give street end number)*: RANDOLPH RD. & WHEATON RD.
4b. City, Town, or Location of Death: WHEATON
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 220-04-7180
6. Sex: 1☒M 2☐F
7. Age *(In yrs. lest birthday)*: 19 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Dey, Year)*: August 31, 1979
9. Birthplece *(Stete or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Germantown
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street end Number: 5 Forest Brook Court
10f. Zip Code: 20874
10g. Citizen of Whet Country?: United States
11. Marital Status: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced
12. Wes Decedent Ever in U,S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*
14. Race - American Indian, Bleck, White, etc. *Specify:* Asian
15. Decedent's Education *(Specify only highest grede completed)*: Elementery/Secondary (0-12): - / College (1-4or 5+): 2
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Patient Escort
16b. Kind of Business/Industry: National Institutes of Health
17. Father's Name *(First, Middle, Last)*: Andy M. Briones
18. Mother's Name *(First, Middle, Maiden Surneme)*: Corazon Madlanbayan
19a. Informant's Neme/Relationship *(Type, Print)*: Andy M. Briones/ Father
19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 5 Forest Brook Court, Germantown, Maryland 20874
20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removel from State 4☐Donation 5☐Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, cremetory or other piece)*: Gate of Heaven Cemetery
Date: November 16, 1998
20c. Location - City or Town, State: Silver Spring, Maryland
21. Signature of Funeral Service Licensee: [signature] M00689
22. Name end Address of Facility: Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Multiple Injuries
Due to (or as e consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in death) Last:
b.
Due to (or as e consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cauae of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24e. Was en eutopsy performed? 1☒Yes 2☒No
24b. Were eutopsy findings available prior to completion of cause of deeth? 1☒Yes 2☒No

25. Was case referred to medical examiner? 1☒Yes 2☐No
26. Plece of Death *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☒Other *(Specify)* SCENE
27. Menner of Death: 1☐Natural 2☒Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Dete of Injury *(Month, Dey Year)*: 11-10-98
28b. Time of Injury: 2234 P M
28c. Injury et Work? 1☐Yes 2☒No
28d. Describe how injury occurred: motor vehicle collision
28e. Plece of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*: street
28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*: Randolph Road Montgomery Co. Md

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated. 2☒ **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, death occurred et the time, dete and place, and due to the cause(s) and manner stated.

29b. Signature end title of certifier: [signature]
29c. License number: O.C.M.E
29d. Date signed *(Month, Dey, Year)*: NOVEMBER 11,1998

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Dennis J Chutenw 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 16 1998
32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Brondfield, Jerome

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37194

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JEROME MARVIN BRONDFIELD
2. Date of Death (Month, Day, Year): November 11, 1998
3. Time of Death: 11:00 A.M.
4a. Facility Name (If not institution, give street and number): Montgomery General Hospital
4b. City, Town, or Location of Death: Olney
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 290-03-5267
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 9, 1913
9. Birthplace (State or Foreign Country): Cleveland, Ohio

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 14801 Pennfield Circle, Apt. #212
10f. Zip Code: 20906
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): | College (1-4or 5+): 5+ Years
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Journalist
16b. Kind of Business/Industry: National Magazine

17. Father's Name (First, Middle, Last): Nathan Brondfield
18. Mother's Name (First, Middle, Maiden Surname): Pauline Solomon

19a. Informent's Name/Relationship (Type, Print): Eric Brondfield, Son
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 115 Dorandes Avenue, San Francisco, California 94116

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other piece): Judean Memorial Gardens | Dete: 11/15/1998
20c. Location - City or Town, State: Olney, Maryland

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name end Address of Facility: STEIN HEBREW MEMORIAL FUNERAL HOME, INC. 232 CARROLL STREET, N.W., WASHINGTON, D.C. 20012

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

BMD

Physician /Medical Examiner

23e. Part1. Enter the diseese, or complicetions that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one ceuse on eech line.

Approximete Intervel Between Onset and Deeth

Immediate Cause (Final diseese or condition resulting in deeth): e. Acute Infero-Posterior Myocardial Infarction — 72 hours
Due to (or es a consequence of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last:
b. Due to (or es e consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was en autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings eveilable prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical exeminer? 1 ☐ Yes 2 ☑ No

26. Place of Deeth (Check only one): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Deeth: 1 ☑ Naturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigetion 6 ☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) and menner es steted. 2 ☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) end menner steted.

29b. Signature and title of certifier: ▶ [signature]
29c. License number: 021334
29d. Date signed (Month, Dey, Year): November 11, 1998

30. Neme end address of person who completed cause of death (Item 23a) (Type, Print): Daniel J. Goldberg 6116 Executive Blvd Rockville, MD 20852

State Registrar

31. Dete filed (Month, Dey, Year): NOV 16 1998
32. Registrer's Signeture: [signature] B. Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

15

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37195

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): JOANNA BROUGHMAN
2. Deta of Daalh: Month November Dey 13 Year 1998
3. Tima of Death: 1303 Pm
4a. Facility Neme (If not institution, give street end numbar): CHURCH HOME AND HOSPITAL
4b. City, Town, or Location of Deeth: BALTIMORE
4c. County of Deeth: N/A

Funeral Director

5. Social Security Number: 228 420 958
6. Sex: 1☐ M 2☑ F
7. Aga (In yrs. last birthday): 64 Yrs.
If Under 1 Yaar: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 30, 1934
9. Birthplece (State or Foreign Country): Virginia

Usuel Residence of Decedent

10a. Slete: Maryland
10b. County: N/A
10c. City, Town or Locelion: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street end Numbar: 2034 Eastern Avenue
10f. Zip Code: 21231-3036
10g. Citizen of What Country?: United States of America

11. Marital Stetus: 1☐ Navar Marriad 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedenl Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaer or Datas:
13. Was Decedent of Hispenic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Rece - American Indian, Black, White, etc. Specify: White

15. Decedent's Educelion (Specify only highast grede completed): Elementary/Secondery (0-12): 12 / College (1-4or 5+):
16a. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired): Disabled
16b. Kind of Business/Industry: None

17. Father's Neme (First, Middle, Last): Elwood Clifton Morton
18. Mother's Name (First, Middle, Meiden Surneme): Ella Roseanna Patnode

19a. Informent's Name/Reletionship (Type, Print): Pat Broughman /Son
19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): P.O. Box 5159, Princeton, West Virginia 24740

20a. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removel from Slata 4☐ Donetion 5☐ Other (Specify)
20b. Plece of Disposition (Name of cematary, cremetory or other place): Metropolitan Crematory
Date: November 14, 1998
20c. Location - City or Town, Slala: Alexandria, Virginia

21. Signeture of Funaral Sarvice Licansee: Karen W. Doll
22. Neme end Address of Facility: Seaver Funeral Service Inc. 24740
1507 North Walker Street, Princeton, West Virgini

DMW

Physician /Medical Examiner

23a. Part I. Entar the diseese, or complicalions thal causad tha death. Do not antar tha moda of dying, such as cardiac or raspiralory arrest, shock, or heert failura. List only one ceuse on eech line.

Approximete Intervel Between Onset end Deeth

Immediate Ceusa (Final disaasa or condition resulting in death)
e. MULTIPLE ORGAN FAILURE — 12 DAYS

Due to (or es e consequenca of):
b. LIVER FAILURE — 2 YEARS

Sequentially list conditions, if eny, leading to Immadiata cause. Enter Underlying Ceuse (Disease or injury thet initiated events resulting in death) Last

Due to (or es e consequence of):
c. RESPIRATORY FAILURE — 12 DAYS

Due to (or as a consequence of):
d. RENAL FAILURE — 12 DAYS

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying cause given in Pert I.
ALCOHOLIC LIVER CIRRHOSIS
BACTERIAL PERITONITIS

23b. Did tobacco uaa contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Wes en eutopsy performed? 1☐ Yas 2☑ No
24b. Were eulopsy findings aveileble prior to completion of ceuse of deeth? 1☐ Yes 2☑ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☑ No
26. Plece of Deeth (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Menner of Deeth: 1☐ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Dete of Injury (Month, Dey Yeer)
28b. Tima of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Physicien:** To the best of my knowledge, death occurred et the time, dete end placa, end due to the ceuse(s) end menner as steted. 2☐ **Medical Examiner:** On the besis of exemination and/or investigation, in my opinion, deeth occurred at tha tima, data and place, and due to the cause(s) and manner steled.
29b. Signature and title of certifier:
29c. Licanse number: D39629
29d. Dale signed (Month, Dey, Yeer): NOVEMBER 13, 1998

30. Name end eddress of person who completed cause of daath (Item 23a) (Type, Print): ALEXANDER SY MD 98 NORTH BROADWAY SUITE 307 BALTIMORE MD 21231

State Registrar

31. Dete filed (Month, Day, Year): NOV 19 1998
32. Registrar's Signeture: Lenora G. Sparks

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37196

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Marjorie Dearing Ball
2. Date of Death Month Dey Yeer: November 16, 1998
3. Time of Death: 11:00 PM
4e Facility Neme *(If not institution, give street and number)*: Sligo Creek Nursing Center
4b. City, Town, or Location of Death: Takoma Park
4c. County of Deeth: Montgomery

Funeral Director

5. Social Security Number: 579-60-2398
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 94 Yrs. — If Under 1 Year: Months / Deys; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: July 28, 1904
9. Birthplece *(State or Foreign Country)*: Maine

Usual Residence of Decedent

10a. Stete: N/A
10b. County: N/A
10c. City, Town or Location: Washington, DC
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1312 Iris Street, NW
10f. Zip Code: 20012
10g. Citizen of Whet Country?: USA

11. Merital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yes, Give Year or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12); College (1-4or 5+): 4
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Kindergarten Teacher
16b. Kind of Business/Industry: DC Public Schools

17. Father's Neme *(First, Middle, Last)*: George H. Ball
18. Mother's Name *(First, Middle, Maiden Surname)*: Alice May Webber

19a. Informent's Neme/Relationship *(Type, Print)*: Elaine R. Lau (Niece)
19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 239 Jinny Hill Raod, Cheshire, CT 06410

20e. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Plece of Disposition *(Name of cemetery, crematory or other place)*: Metropolitan Crematory
Dete: 11/18/98
20c. Location - City or Town, Stete: Alexandria, Virginia

21. Signeture of Funeral Service Licensee: Eric S. Scales
22. Name end Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver SPring, MD 20901

Physician /Medical Examiner

23a. Pert I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. — Approximate Intervel Between Onset end Death

Immediate Ceuse (Final disease or condition resulting in deeth)
a. Alzheimer's Disease — 5 years
Due to (or es a consequence of):

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last
b.
Due to (or es e consequence of):
c.
Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an eutopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homlcide 5☐ Pending investigetion 6☐ Could not be determined
28a. Dete of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end place, end due to the ceuse(s) end menner es stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date end placa, end due to the cause(s) end menner steted.

29b. Signeture and title of certifier: George F. Sengstack M.D.
29c. License number: D12121
29d. Date signed *(Month, Day, Year)*: November 18, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): George F. Sengstack, M.D., 3929 Ferrara Drive, Wheaton, MD 20906

State Registrar

31. Dete filed *(Month, Day, Year)*: NOV 19 1998
32. Registrer's Signature: Barbara G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37197

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Dete of Death Month / Day / Yeer	3. Time ot Death
ROBERT BATCHELDER, JR.	NOVEMBER 10, 1998	2:00 PM

4e Feclity Name (If not institution, give street end number)	4b. City, Town, or Location of Deeth	4c. County of Death
HOLY CROSS HOSPITAL	SILVER SPRING	MONTGOMERY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Dey, Year)	9. Birthplece (State or Foreign Country)
272-01-8877	1 [X] M 2 [ ] F	85 Yrs.			12/12/12	OHIO

Usual Residence of Decedent

10e. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	MONTGOMERY	SILVER SPRING	1 [ ] Yes 2 [X] No

10e. Street end Number	10f. Zip Code	10g. Citizen ot Whet Country?
308 BURNT MILLS AVE	20901	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - American Indian, Bleck, White, etc.
1 [ ] Never Merried 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grede completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind ot Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	1	RADIO FIELD ENGINEER	VOICE OF AMERICA

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surneme)
ROBERT BATCHELDER, SR.	HAZEL E. KULLMAN

19a. Informant's Name/Reletionship (Type, Print)	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)
ALDONNA BATCHELDER / WIFE	308 BURNT MILLS AVE. SILVER SPRING MD 20901

20a. Method ot Disposition	20b. Placa of Disposition (Neme of cemetery, cremetory or other place)	Dete	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	GATE OF HEAVEN CEMETERY	11/14/98	SILVER SPRING, MD

21. Signature of Funeral Service Licensee ▶ [signature]

22. Neme end Address of Feclity HINES-RINALDI FUNERAL HOME, INC.
11800 NEW HAMPSHIRE AVE. SILVER SPRING MD 20904

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

		Approximete Interval Between Onset end Death
Immediate Cause (Final diseese or condition resulting in deeth)	a. CARDIC ARRYTHMIA	1 HR.
Due to (or as a consequenca of):		
Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest	b. ATHERSCLEROTIC CARDIOVASCULAS DISEASE	LONG TERM
Due to (or as e consequenca ot):		
	c. DIABETES MELLITUS	LONG TERM
Due to (or as e consequence of):		
	d. RENAL FAILURE	LONG TERM

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

STAPH SEPSIS

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [X] Unknown

24a. Was en autopsy performed?	24b. Were autopsy findings eveilable prior to completion ot cause ot death?
1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner?	26. Plece ot Death (Check only one)	
1 [X] Yes 2 [ ] No	Hospitel: 1 [X] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death	28a. Date ot Injury (Month, Dey Year)	28b. Time ot Injury	28c. Injury et Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	
	28e. Placa of Injury - At home, ferm, street, fectory, office building, etc. (Specify)			28t. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one) 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and piece, end due to the cause(s) and manner es stated.
2 [ ] **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end piece, end due to the cause(s) end menner stated.

29b. Signeture and title ot certifier	29c. License number	29d. Date signed (Month, Dey, Year)
▶ V. SINGH	D19897	11.11.98

30. Name and address ot person who completed cause ot deeth (Item 23a) (Type, Print) V. SINGH 7209 A HANOVER PARKWAY GREEN BELT MD 20770

State Registrar

31. Dete tiled (Month, Day, Year)	32. Registrer's Signature
NOV 16 1998	G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pega 2 should be detached for usa es the buriel-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Meryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37198

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Vivian Estelle Barkley
2. Date of Death (Month, Day, Year): Nov. 8, 1998
3. Time of Death: 5:50 AM
4e. Facility Name *(If not institution, give street end number)*: Brighton Gardens of Tuckerman
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-24-1564
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Jan. 3, 1916
9. Birthplace *(State or Foreign Country)*: Wash., D.C.

Usual Residence of Decedent

10e. State: Md.
10b. County: Montgomery
10c. City, Town or Location: Bethesda
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 5550 Tuckerman Lane
10f. Zip Code: 20852
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 7 | College (1-4or 5+):
16e. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: File Clerk
16b. Kind of Business/Industry: Crestar

17. Father's Name *(First, Middle, Last)*: Clinton Wells
18. Mother's Name *(First, Middle, Maiden Surname)*: Eva Nash

19e. Informant's Name/Relationship *(Type, Print)*: Theda Clements /sister
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5100 Dorest Ave. Bethesda, MD 20815

20e. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Cedar Hill | Date: Nov.11'98
20c. Location - City or Town, State: Suitland, MD

21. Signature of Funeral Service Licensee: John F. DeVol
22. Name and Address of Facility: DeVol Funeral Home 2222 Wisconsin Ave., NW Washington, D.C. 20007

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death)
e. cardiac failure

Due to (or as e consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Lest
b. Atherosclerosis

Due to (or es e consequenca of):

c.

Due to (or es e consequence of):

d.

Part II. **Other eignificent conditions** contributing to death but not resulting in the underlying cause given in Part I.
dementia, encephalopathy

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No
26. Piece of Death *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28e. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Placa of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Phyeician:** To the best of my knowledge, death occurred et the time, date end piece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the besis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner stated.

29b. Signeture end title of certifier: Albert K Lee M.D.
29c. License number: D31282
29d. Date signed *(Month, Dey, Year)*: Nov. 9,1998

30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print): Albert Lee, M.D. 8218 Wisconsin Ave. #105 Bethesda, MD 20815

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 16 1998
32. Registrer's Signeture: Geneva G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Merylend Department of Health end Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37199

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Data of Death Month Day Year	3. Time of Death
ADELE	M.	BELL	November 14, 1998	1:31 PM

4a Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Carriage Hill Bethesda	BETHESDA	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Data of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
577-36-2275	1☐ M 2☒ F	94 Yrs.			April 11,1904	Pennsylvania

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
---	---	Washington, D.C.	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3408 Legation Street, N.W.	20015	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8		homemaker	own home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
"Unknown" Daugirda	Margaret "Unknown"

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Joan Robinson, Daughter	P. O. Box 216 Irvington, Virginia 22480

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Metropolitan Crematory	Nov. 16, 1998	Alexandria, Virginia

21. Signature of Funeral Service Licensee ▶ Gary M. Price

22. Name and Address of Facility: DeVol Funeral Home, 10 E. Deer Park Drive, Gaithersburg, MD 20877

Physician /Medical Examiner

23a. Part I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. SEPSIS	10 DAYS
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. URINARY RETENTION	1+ YEAR
Due to (or as a consequence of):		
	c.	
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HYPOTHYROID, CHRONIC OBSTRUCTIVE PULMONARY DISEASE, OSTEOARTHRITIS, URINARY RETENTION, INDWELLING CATHETER RECURRENT URINARY TRACT INFECTIONS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	D35579	NOVEMBER 16, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Susan J. Miller M.D. 6844 Tulip Hill Terrace Bethesda, Md.20816

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 19 1998	▶ Jeanne B. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37200

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Kathleen Benson
2. Date of Death: Month November Day 16, Year 1998
3. Time of Death: 7:45 A.M.
4a. Facility Name (If not institution, give street and number): Montgomery General Hospital
4b. City, Town, or Location of Death: Olney
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 075-01-6246
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 80 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 3, 1918
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3701 International Drive, Apt. 245
10f. Zip Code: 20906
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Thomas Luddy
18. Mother's Name (First, Middle, Maiden Surname): Margaret Kiely

19a. Interment's Name/Relationship (Type, Print): Paul J. Benson (husband)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3701 International Drive, Apt. 245, Silver Spring, MD 20906

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory | Date: 11/16/98
20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: Robert E. Ramsey
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Lung Cancer — Due to (or as a consequence of): — One Year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. — Due to (or as a consequence of):
c. — Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D 33886
29d. Date signed (Month, Day, Year): November 16, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): [illegible] MD 18511 Prince Philip Dr. Olney, MD 20832

State Registrar

31. Date filed (Month, Day, Year): NOV 18 1998
32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37201

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): OSER I. BERMANT
2. Date of Death (Month, Day, Year): November 14, 1998
3. Time of Death: 7:00 PM
4a. Facility Name (If not institution, give street and number): Suburban Hospital
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 080-18-3512
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 71 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 4, 1927
9. Birthplace (State or Foreign Country): Brooklyn, NY

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Potomac
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 11029 Seven Hill Lane
10f. Zip Code: 20854
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: Navy
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): College (1-4or 5+): 6+ Years
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Mediator
16b. Kind of Business/Industry: Concordia Systems Group

17. Father's Name (First, Middle, Last): Ralph Bermant
18. Mother's Name (First, Middle, Maiden Surname): Julia Billauer

19a. Informant's Name/Relationship (Type, Print): Lili Bermant, Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11029 Seven Hill Lane, Potomac, Maryland 20854

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Northern Virginia Crematory
Date: November 17, 1998
20c. Location - City or Town, State: Arlington, Virginia

21. Signature of Funeral Service Licensee: ▶ William A. Halpert
22. Name and Address of Facility: STEIN HEBREW MEMORIAL FUNERAL HOME, INC. 232 CARROLL STREET, NW, WASHINGTON, DC 20012

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
e. Subarachnoid bleed
Due to (or as a consequence of):
b. Intra cerebral bleed

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Brajendra N Misra M.D., M.S., FACS
29c. License number: D 20069
29d. Date signed (Month, Day, Year): 15 Nov 98

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): DR. BRAJENDRA N MISRA 7229 HANOVER PARKWAY Suite A GREENBELT MD 20770

State Registrar

31. Date filed (Month, Day, Year): NOV 19 1998
32. Registrar's Signature: Jeanne G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

BM 11/14/98 7:00pm 10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37202

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Margaret A. Brandt
2. Date of Death: Month November Day 17 Year 1998
3. Time of Death: 2030
4a. Facility Name (If not institution, give street and number): Manor Care Ruxton
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212-01-9514
6. Sex: 1☐ M 2☒ F
7. Age (in yrs. last birthday): 98 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct 17, 1900
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Howard
10c. City, Town or Location: Ellicott City
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 4822 Rollingtoo Road
10f. Zip Code: 21043
10g. Citizen of What Country? United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 1☐ Yes 2☒ No Specify:
14. Race - Amarican Indien, Bleck, White, etc. Specify: White

15. Dacadent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): unknown
College (1-4or 5+):
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): unknown Nagengast
18. Mother's Name (First, Middle, Maidan Surname): unknown

19a. Informent's Name/Relationship (Type, Print): Louise Gonzales/Executor
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 100 N Charles St Suite 630 Balt., MD 21201

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☒ Other (Spacify) entombment
20b. Place of Disposition (Name of cemetary, crematory or other place): Lorraine Park Cemetery
Deta: 11-20-98
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Servica Licensea: ▶ Sharon A Collins - With
22. Name and Address of Facility: Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that causad the death. Do not enter the moda of dying, such as cerdiac or respiretory arrast, shock, or heert failure. List only one ceuse on each line.

Approximata Intervel Between Onset and Deeth

Immediate Cause (Final disease or condition resulting in death): e. STROKE — years.

Due to (or as e consequence ot):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last

b.

Due to (or es a consequence of):

c.

Due to (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying causa given in Part I.

23b. Did tobacco use contributa to the cauaa of death? 1☐ Yas 2☐ No 3☐ Probably 4☒ Unknown

24a. Was en autopsy performad? 1☐ Yes 2☒ No

24b. Were autopsy tindings available prior to completion ot ceusa of deeth? 1☐ Yes 2☐ No

25. Wes cese reterred to medicel exeminer? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner ot Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date ot Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, tarm, street, factory, offica building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Phyaiclen:** To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and manner as stated. 2☐ **Medical Examinar:** On the basis ot examination and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the ceuse(s) and manner statad.

29b. Signatura and title of certifier: ▶ A.H. Ghiladi
29c. Licansa number: D0012849
29d. Date signad (Month, Day, Year): 11-18-98

30. Name and eddress ot person who completed ceuse of death (Item 23a) (Type, Print): A.H. GHILADI, M.D. 7600 OSLER Dr. TOWSON, MD 21204

State Registrar

31. Dete tiled (Month, Day, Yaar): NOV 19 1998
32. Registrar's Signatura: ▶ Donna B. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37203

THOMAS S. BRADY
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name *(First, Middle, Last)*: Thomas Smith Brady, Jr.					2. Date of Death Month: NOV Day: 2 Year: 1998			3. Time of Death: 9:35 AM
4a. Facility Name *(If not institution, give street and number)*: The Memorial Hospital				4b. City, Town, or Location of Death: Easton			4c. County of Death: Talbot	
5. Social Security Number: 213-40-9568	6. Sex: 1☐M 2☐F	7. Age *(In yrs. last birthday)*: 57 Yrs.	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth *(Month, Day, Year)*: July 14, 1941			9. Birthplace *(State or Foreign Country)*: Maryland
Usual Residence of Decedent								
10a. State: Md.	10b. County: Caroline	10c. City, Town or Location: Greensboro					10d. Inside City Limits: 1☐Yes 2☒No	
10e. Street and Number: 25489 Shad Run Way		10f. Zip Code: 21639			10g. Citizen of What Country?: U.S.A.			
11. Marital Status: 1☐Never Married 2☐Married ☒Widowed 4☐Divorced	12. Was Decedent Ever in U.S. Armed Forces? ☒Yes 2☐No If Yes, Give Year or Dates: 59-62	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes ☒No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10 / College (1-4or 5+)		16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Warehouse Loader			16b. Kind of Business/Industry: Giant Food Industry			
17. Father's Name *(First, Middle, Last)*: Thomas Smith Brady, Sr.					18. Mother's Name *(First, Middle, Maiden Surname)*: Lula Marquess			
19a. Informant's Name/Relationship *(Type, Print)*: Dale R. Brady (Son)		19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 135 Pleasant Springs Dr., Centreville, Md. 21617						
20a. Method of Disposition: ☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*		20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Md. Veteran's Cemetery			Date: Nov. 5, 1998		20c. Location - City or Town, State: Hurlock, Md.	
21. Signature of Funeral Service Licensee: Thomas K. Helfenbein		22. Name and Address of Facility: Fellows, Helfenbein & Newnam Funeral Home 408 S. Liberty St., Centreville, Md.						

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirelory arrest, shock, or heert failure. List only one cause on each line.

Approximeta Intarval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)
a. Ischemic Colitis — 3 days

Due to (or as a consequance of):

Sequantially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequance of):
c.
Due to (or as a consequanca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
1) Congestive Heart Failure

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death *(Check only one)*: Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day, Year)* | 28b. Time of Injury M | 28c. Injury at Work? 1☐Yes 2☐No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)* | 28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed *(Month, Day, Year)*
Dennis M. DeShields	D 53110	11/2/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dennis DeShields; 219 S. Washington St., Easton, Md. 21601

State Registrar

31. Date filed *(Month, Day, Year)*	32. Registrar's Signature
NOV 04 1998	Geneva G. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37204

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Madeline V. Collins
2. Date of Death (Month, Day, Year): November 20, 1998
3. Time of Death: 1240
4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER
4b. City, Town, or Location of Death: SALISBURY
4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 227-11-5089
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 37 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 1-12-61
9. Birthplace (State or Foreign Country): VA.

Usual Residence of Decedent

10a. State: MD
10b. County: Worcester
10c. City, Town or Location: Pocomoke
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 708 Clark Avenue
10f. Zip Code: 21851
10g. Citizen of What Country? U. S. A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): 10th
Elementary/Secondary (0-12) / College (1-4or 5+)
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cashier
16b. Kind of Business/Industry: Restaurant

17. Father's Name (First, Middle, Last): Russell Knox
18. Mother's Name (First, Middle, Maiden Surname): Frances Hazel Schoolfield

19a. Informant's Name/Relationship (Type, Print): Frances Hazel Knox-mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3292 Fleming Rd. Horntown, Va. 23395

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Trinity U.M. Cemetary
Date: 11-28-98
20c. Location - City or Town, State: Pocomoke City, md. 21851

21. Signature of Funeral Service Licensee: John A. Prince
22. Name and Address of Facility: Bennie Smith Funeral Home P. O. Box 331 Pocomoke City, md. 21851

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Congestive Heart Failure
Due to (or as a consequence of):
b. CARDIOMYOPATHY

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. 2☐ **Medicat Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Paul R. Fleury
29c. License number: D24872
29d. Date signed (Month, Day, Year): 11/23/98

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): PAUL FLEURY 305 TENTH ST POCOMOKE CITY MD

State Registrar

31. Date filed (Month, Day, Year): NOV 24 1998
32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Madelyn V. Collins 227-11-5089

5

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37205

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CATHERINE CALLAHAN
2. Date of Death: Month NOVEMBER Day 07 Year 1998
3. Time of Death: 2400
4a. Facility Name (If not institution, give street and number): Suburban Hospital
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 410-64-2164
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 24, 1919
9. Birthplace (State or Foreign Country): Tennessee

Usual Residence of Decedent

10e. State: N/A
10b. County: N/A
10c. City, Town or Location: Washington, D.C.
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 4530 Connecticut Avenue, N.W. #404
10f. Zip Code: 20016
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): +4 College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Lt. Commander
16b. Kind of Business/Industry: U.S. Navy
17. Father's Name (First, Middle, Last): Malcolm Callahan
18. Mother's Name (First, Middle, Maiden Surname): Mary Lee Dodson
19a. Informant's Name/Relationship (Type, Print): Wade Atkinson Brother-in-law
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10837 Broadwater Drive, Fairfax, VA 22032
20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Crematory Baltimore/Washington
Date: 11/13
20c. Location - City or Town, State: Laurel Maryland
21. Signature of Funeral Service Licensee: ▶ Joseph Gawler's Sons, Inc.
22. Name and Address of Facility: Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave. N.W., Washington, D.C. 20016

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. PNEUMONIA	1 DAY
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. CHRONIC OBSTRUCTIVE LUNG DISEASE	YEARS
Due to (or as a consequence of):		
	c.	
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ D. Vikramaditya Reddy MD
29c. License number: D43464
29d. Date signed (Month, Day, Year): NOVEMBER - 08 - 1998

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): VIKRAMADITYA D. REDDY, 11175 ROCKVILLE PIKE, SUITE 303, ROCKVILLE, MD - 20852

State Registrar

31. Date filed (Month, Day, Year): NOV 16 1998
32. Registrar's Signature: B. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

DHW

CATHERINE CALLAHAN 11-7-98 12 midnight

10

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37206

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*	2. Date of Death Month / Day / Year	3. Time of Death
Sarah D. Chandler	November 11, 1998	12:30AM

4a. Facility Name *(If not institution, give street and number)*	4b. City, Town, or Location of Death	4c. County of Death
Doctor's Community Hospital	Lanham	Prince Georges

Funeral Director

5. Social Security Number	6. Sex	7. Age *(In yrs. last birthday)*	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth *(Month, Day, Year)*	9. Birthplace *(State or Foreign Country)*
248-22-5784	1☐ M 2☒ F	88 Yrs.			Nov. 10, 1910	SC

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
SC	Williamsburg	Nesmith	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
Route 1, Box 30	29850	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No *Specify:*	*Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*		16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
unk		Housewife	Home

17. Father's Name *(First, Middle, Last)*	18. Mother's Name *(First, Middle, Maiden Surname)*
Hampton Dorsey	Rosa Cooper

19a. Informant's Name/Relationship *(Type, Print)*	19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*
Hampton Chandler / son	719 Kaplan Court, Landover, MD 20785

20a. Method of Disposition	20b. Place of Disposition *(Name of cemetery, crematory or other place)*	Date	20c. Location - City or Town, State
1☐ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other *(Specify)*	Gr. Mt. Ararat Cemetery	11/14/98	Nesmith, SC

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ R N Horton	R. N. Horton Co. Morticians, Inc. 600 Kennedy Street, N.W., Wash., DC 20011

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)	e. Ovarian Cancer	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Weight Loss,

Gastritis, Hiatal Hernia - Lymphoma

23b. Did tobacco use contribute to the cause of death?
1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☑ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death *(Check only one)*	
1☐ Yes 2☑ No	Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death	28a. Date of Injury *(Month, Day, Year)*	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*			28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*

1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed *(Month, Day, Year)*
▶	D 53411	11/11/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jadish Shesadri, M.D. 3060 Mitchellville Road, Suite 103, Bowie, MD 20716

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

2

State Registrar

31. Date filed *(Month, Day, Year)*	32. Registrar's Signature
NOV 17 1998	G. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37207

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: HELEN R. COSBY
2. Date of Death (Month, Day, Year): NOV. 17, 1998
3. Time of Death: 1300
4a. Facility Name *(If not institution, give street and number)*: SHADY GROVE ADVENTIST HOSPITAL
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 252-20-6863
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 76 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Apr. 6, 1922
9. Birthplace *(State or Foreign Country)*: Georgia

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Gaithersburg
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 9316 Jarrett Court
10f. Zip Code: 20886
10g. Citizen of What Country?: U.S.A.

11. Marital Status: ☒ 1 Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): — College (1-4or 5+): 2 yrs
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Nurse
16b. Kind of Business/Industry: Medical

17. Father's Name *(First, Middle, Last)*: George E. King
18. Mother's Name *(First, Middle, Maiden Surname)*: Eunice Vinson

19a. Informant's Name/Relationship *(Type, Print)*: Krista Cosby (Daughter)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 9316 Jarrett Court, Gaithersburg, MD 20886

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Carl Williams F/Home — Date: 11/19/98
20c. Location - City or Town, State: Atlanta, GA

21. Signature of Funeral Service Licensee: George E. Snowden
22. Name and Address of Facility: SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850

dmd

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CARDIORESPIRATORY ARREST — MINUTES

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

BLEEDING GASTRIC ULCERS

RENAL FAILURE, OBSTRUCTIVE UROPATHY

OVARIAN CANCER

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: G Sagayadan MD
29c. License number: D43358
29d. Date signed *(Month, Day, Year)*: NOVEMBER 18, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GRACE E. SAGAYADAN, MD
849-C QUINCE ORCHARD BLVD, GAITHERSBURG, MD 20878

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 20 1998
32. Registrar's Signature: Jeanne G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37208

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Marie A. Coleman

2. Date of Death — Month: November Day: 17 Year: 1998

3. Time of Death: 9:00 PM

4e. Facility Name (If not institution, give street and number): Magnolia Nursing Home

4b. City, Town, or Location of Death: Lanham

4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 168-16-5271

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 78 Yrs.

If Under 1 Year — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Date of Birth (Month, Day, Year): Aug. 8, 1920

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: MD

10b. County: Prince Georges

10c. City, Town or Location: College Park

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3600 Marlbrough Way

10f. Zip Code: 20740

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Theodore Rodman

18. Mother's Name (First, Middle, Maiden Surname): Maria Anna Nicklas

19e. Informant's Name/Relationship (Type, Print): Richard E. Coleman (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3600 Marlbrough Way, College Park, MD 20740

20e. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory

Date: 11/18/98

20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: James E Dodd

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. acute myocardial infarction — sudden

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Atherosclerotic heart disease — years

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

advanced senile dementia with chronic vegetative state; multiple cerebrovascular accidents

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29e. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Peter M Schissler MD

29c. License number: D 22780

29d. Date signed (Month, Day, Year): 11/18/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Peter M Schissler MD 7500 Greenway Ctr. Dr. Greenbelt, Md 20770

State Registrar

31. Date filed (Month, Day, Year): NOV 19 1998

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37209

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Lynn Pulliam Coe

2. Date of Death: Month November Day 13, Year 1998

3. Time of Death: 11:00 a.m.

4a. Facility Name *(If not institution, give street and number)*: Brighton Gardens

4b. City, Town, or Location of Death: Bethesda

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 578-03-3351

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Nov. 5, 1913

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Montgomery

10c. City, Town or Location: Chevy Chase

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 5555 Friendship Blvd,

10f. Zip Code: 20815

10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grede completed)*: Elamantary/Secondery (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working lifa. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Fether's Name *(First, Middle, Last)*: Claude E. Pulliam

18. Mother's Neme *(First, Middle, Maiden Surneme)*: Nan Miller

19a. Informent's Name/Reletionship *(Type, Print)*: Raymond G. Coe Husband

19b. Meiling Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 5555 Friendship Blvd., Chevy Chase, MD 20815

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Name of cemetery, cremetory or other piece)*: Rock Creek Cemetery

Date: 11/17

20c. Location - City or Town, State: Washington, D.C.

21. Signature of Funerel Service Licensee: Joseph G. Gawler

22. Name and Address of Facility: Joseph Gawler's Sons, Inc. 5130 Wisconsin Avenue N.W., Washington, D.C. 20016

Physician /Medical Examiner

23a. Part1(Enter the diseases, or complications thet caused the death. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximete Intarval Batween Onsat and Deeth

Immediate Ceuse (Final disease or condition resulting in deeth)

e. coronary artery disease

Due to (or as a consaquence of):

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in deeth) Lest

b. dementia

Due to (or es e consequance of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobecco uee contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was en eutopsy performed? 1☐ Yes 2☒ No

24b. Ware eutopsy findings eveilable prior to completion of ceuse of daeth? 1☐ Yas 2☐ No

25. Wes cese referrad to medicel examiner? 1☐ Yes 2☒ No

26. Piece of Deeth *(Chack only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To tha best of my knowledge, deeth occurred et tha tima, data and piece, end due to tha ceuse(s) end mannar as steted. 2☐ **Medical Examiner:** On the basis of exemination and/or investigation, in my opinion, deeth occurrad at tha tima, dete end place, end dua to tha ceusa(s) and menner stated.

29b. Signeture end title of certifier: Albert Lee MD

29c. License number: D31282

29d. Date signed *(Month, Dey, Year)*: November 16, 1998

30. Neme end address of person who completed causa of death (Item 23e) (Type, Print): Albert Lee, M.D. 8218 Wisconsin Avenue, #105, Bethesda, MD 20814

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 18 1998

32. Registrer's Signeture: Geneva G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: Tha law requires that tha death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by tha attending physician and completely filled in by tha funeral director, page 2 should be detached for usa as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37210

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Robert Francis Cissel, Sr.

2. Date of Death (Month, Day, Year): November 12, 1998

3. Time of Death: 3:50 PM

4a. Facility Name (If not institution, give street and number): 10423 Haywood Drive

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 216-16-0333

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 76 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 11, 1922

9. Birthplace (State or Foreign Country): Washington,D.C.

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Insida City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 10423 Haywood Drive

10f. Zip Code: 20902

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No If Yes, Give Year or Dates: unknown

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, Whita, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Superintendent

16b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): Harry T. Cissel

18. Mother's Name (First, Middle, Maiden Surname): Mary Alice Wills

19a. Informant's Name/Relationship (Type, Print): Patricia A. Kinney (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10423 Haywood Drive Silver Spring,Maryland 20902

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory

Date: 11/15/98

20c. Location - City or Town, State: Alexandria,Virginia

21. Signature of Funeral Service Licensee: Andrew J. Cole

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd.,W.,Silver Spring,MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line.

Approximala Intarval Between Onset and Death

Immediale Cause (Final disease or condition resulting in death)

a. Acute Renal Failure — 2 weeks

Due to (or as a consequence of):

b. Multiple Myeloma — 10 months

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

Vascular Disease

Aortic Aneurysm

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Linda M Burrell MD

29c. License number: D 35996

29d. Data signed (Month, Day, Year): November 13, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Linda M. Burrell, M.D. 2101 Medical Park Drive #210 Silver Spring,Maryland 20901

State Registrar

31. Date filed (Month, Day, Year): NOV 17 1998

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

98-6615-031
CMK
ANN L. CAMPBELL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37211

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Anne Lenore Campbell	NOVEMBER 13, 1998	2316PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
HOLY CROSS HOSPITAL	SILVER SPRING	MONTGOMERY COUNTY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-74-9437	1☐ M 2☒ F	83 Yrs.			October 1, 1915	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Silver Spring	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
203 Williamsburg Drive	20901	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Roy B. Johnson	Lotta B. Sapp

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
David R. Campbell/Son	11702 Leona Street, Wheaton, Maryland 20902

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Montgomery Crematorium, Inc.	Nov. 17, 1998	Bethesda, Maryland

21. Signature of Funeral Service Licensee		22. Name and Address of Facility
▶ Michael E. Hagner	M00846	Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset end Death
Immediate Cause (Final disease or condition resulting in death)	a. Head Injury	
	Due to (or as a consequence of):	
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or es e consequence of):	
	d.	

Part II. **Other significent conditiona** contributing to death but not resulting in the underlying cause given in Part I.

Atherosclerotic cardiovascular disease

23b. Did tobecco use contribute to the ceuae of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was en autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☑ Yes 2☐ No	1☑ Yes 2☐ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒ Yes 2☐ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐ Natural 2☑ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined	11-13-98	1730 M	1☐ Yes 2☑ No	Subject Fell

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Hospital	Holy Cross Hospital Montgomery County

29a. Certifier (Check only one)
1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated.
2☒ **Medical Examiner**: On the basis of examination end/or investigation, In my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	O.C.M.E.	NOVEMBER 15, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
David R Fowler 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 16 1998	Geneva D. Sparks

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 37212

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Harryett Crump
2. Date of Death (Month, Day, Year): Nov. 23 1998
3. Time of Death: 4:30pm
4a. Facility Name (If not institution, give street and number): Southern Maryland Hospital
4b. City, Town, or Location of Death: Clinton
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 577 07 9489
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 88 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug 27, 1910
9. Birthplace (State or Foreign Country): Washington DC

Usual Residence of Decedent

10a. State: MD
10b. County: P.G.
10c. City, Town or Location: District Heights
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 6714 Halleck Street
10f. Zip Code: 20747
10g. Citizen of Whet Country?: United States

11. Maritat Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usuaf Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary
16b. Kind of Business/Industry: Furniture Company

17. Father's Name (First, Middle, Last): Edward Meyer
18. Mother's Name (First, Middle, Maiden Surneme): Mamie UNKNOWN

19a. Informent's Neme/Relationship (Type, Print): Robert E. Crump, Jr. (SON)
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 6714 Halleck Street, District Heights, Md 20747

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removet from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Cedar Hill Cemetery
Dete: Nov 30, 1998
20c. Location - City or Town, Stete: Suitland, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name end Address of Facility: Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Md 20735

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line.

		Approximete Interval Between Onset and Deeth
Immediete Cause (Final disease or condition resulting in death) a.	Urosepsis	7dy
Due to (or as a consequence of): b.	Chronic Myelogenic Leukemia	2yr
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last — Due to (or as a consequence of): c.	Hypothyroidism	1½yr
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Wes an eutopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was case referred to medicaf examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospitef: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted.

29b. Signature and title of certifier: [signature] MD Attendg
29c. License number: D-24535
29d. Date signed (Month, Day, Year): 11.24.98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Laxmi Berwa 7700 Old Branch Ave C-101 Clinton MD 20735

10

State Registrar

31. Date filed (Month, Day, Year): NOV 25 1998
32. Registrar's Signature: [signature] B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend #18, Fusz, 11/24/98,drw

Certificate of Death

Reg. No. 98 37213

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death (Month, Day, Year)	3. Time of Death
JAMES	EDWARD	CARNES	NOVEMBER 22, 1998	0339

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Calvert Memorial Hospital	Prince Frederick	Calvert

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215 28 9119	1☐M 2☒F	65 Yrs.			April 21, 1933	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Calvert	St. Leonard	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6085 Long Beach Drive	20685	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☐Widowed 4☒Divorced	1☐Yes 2☐No If Yes, Give Year or Dates: Korea	1☐Yes 2☒No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Quality Control Tec	Baltimore Gas & Electric

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
James Edward Carnes, Sr.	Katherine ~~Vosz~~ Fusz

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Michelle C. trott- daughter	11340 Southern Md. Blvd. Dunkirk MD 20754

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Metropolitan Funeral Service	Nov 25 1998	Alexandria Virginia

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ BRausch	Rausch Funeral Home PA 4405 Broomes Is. Rd. Port Republic MD 2067

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ASCVD	unknown
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequance of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23b. **Did tobacco use contribute to the cause of death?** 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

29a. Certifier (Check only one)	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
1☐Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	▶ D Gallatin	D51949	11/22/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. David R Gallatin, M.D. Prince Frederick, Maryland 20678

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 23 1998	▶ B. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37214

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): RENATE CAVE
2. Date of Death (Month, Day, Year): NOVEMBER 23, 1998
3. Time of Death: 08:40AM
4a. Facility Name (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE CITY
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 578 50 2020
6. Sex: 1☐ M 2☐ F
7. Age (In yrs. last birthday): 62 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug 16, 1936
9. Birthplace (State or Foreign Country): Germany

Usual Residence of Decedent

10a. State: MD
10b. County: P.G.
10c. City, Town or Location: Clinton
10d. Inside City Limits: 1☐ Yes 2☐ No XX
10e. Street and Number: 6601 Springbrook Lane
10f. Zip Code: 20735
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 5
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Translator
16b. Kind of Business/Industry: FBI

17. Father's Name (First, Middle, Last): Maxmillan Ulrich
18. Mother's Name (First, Middle, Maiden Surname): Lottchen Kleeberg

19a. Informant's Name/Relationship (Type, Print): Robert Cave (HUSBAND)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6601 Springbrook Lane, Clinton, Maryland 20735

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Resurrection Cemetery
Date: Nov 28, 1998
20c. Location - City or Town, State: Clinton, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Md 20735

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. metastatic adenocarcinoma — 4 weeks

Due to (or as a consequence of):
b.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] Shannon J. Winakur MD
29c. License number: RES - 000
29d. Date signed (Month, Day, Year): November 23, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SHANNON J WINAKUR MD, JOHNS HOPKINS HOSPITAL, 600 N. WOLFE ST, BALTIMORE, MARYLAND 21287

State Registrar

31. Date filed (Month, Day, Year): NOV 25 1998
32. Registrar's Signature: [signature] Geneva G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37215

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Albert Westley Downing
2. Data of Death — Month: 11 Day: 14 Yeer: 98
3. Time of Deeth: 3 AM
4a. Facility Nama (If not institution, give straat and number): LAYHill CENTER
4b. City, Town, or Location of Daath: SILVER SPRING
4c. County of Deeth: MONGOMERY

Funeral Director

5. Social Security Number: 220-28-4696
6. Sax: 1☒M 2☐F
7. Age (In yrs. last birthday): 97 Yrs.
If Under 1 Yaar — Months / Deys
If Under 24 Hrs. — Hours / Min.
8. Dete of Birth (Month, Day, Year): 05-02-1901
9. Birthpleca (State or Foreign Country): Hopeton VA

Usuel Residence of Decedent

10a. State: Md
10b. County: montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street end Number: 15644 Cliff Swallow way
10f. Zip Code: 20853
10g. Citizan of Whet Country?: United States

11. Maritel Status: 1☐Never Married 2☐Merried 3☒Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Yaar or Dates:
13. Wes Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puarto Rican, atc.): 1☐Yas 2☒No Specify:
14. Raca - American Indien, Bleck, White, etc. Specify: Black

15. Decedent's Education (Specify only highast grade completed): Elementery/Secondery (0-12): grade school; College (1-4or 5+):
16a. Decedent's Usuel Occupation (Giva kind of work dona during most of working life. DO NOT use retired): CONSTRUCTION
16b. Kind of Business/Industry: Building

17. Father's Nema (First, Middla, Last): Westley Downing
18. Mother's Neme (First, Middle, Maidan Sumama): Margie ?

19a. Informant's Name/Reletionship (Type, Print): Shirley Finney (Dght)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 15644 Cliff Swallow Rockville MD 20853

20a. Method of Disposition: 1☒Burial 2☐Cremetion 3☐Removel from Stata 4☐Donetion 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, cramatory or other place): WHARTON FUNERAL HOME
Dete: 11/21/98
20c. Location - City or Town, State: 22171 - Wharton Rd Accomac VA 23301

21. Signature of Funeral Service Licensee: [signature]
22. Name end Address of Facility: 22171 Wharton Rd Wharton Funeral Home

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications that caused the deeth. Do not entar tha moda of dying, such as cardiac or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Intervai Between Onset and Death

Immediete Cause (Finel diseese or condition resulting in deeth): a. Pneumonia — 1 week

Due to (or es a consequence of):

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury thet initieted events resulting in deeth) Last:
b.
Due to (or es e consequence of):
c.
Due to (or es a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Wes an autopsy performed? 1☐Yas 2☒No
24b. Were eutopsy findings avelieble prior to completion of cause of death? 1☐Yas 2☐No

25. Wes case referred to medicaf examiner? 1☐Yes 2☒No
26. Piece of Deeth (Check only one): Hospitel: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Rasidanca 6☐Other (Specify)

27. Manner of Deeth: 1☒Naturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Invastigation 6☐Could not be determined
28a. Date of Injury (Month, Day Yaar)
28b. Time of Injury M
28c. Injury at Work? 1☐Yas 2☐No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted. 2☐**Medical Examiner:** On the besis of examinetion end/or investigetion, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) end menner stated.

29b. Signeture and Title of certifier: [signature]
29c. License number: D38262
29d. Dete signed (Month, Day, Year): NOV 15, 1998

30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print): Dr Mendhiralta 18111 N. Philip Dr. Olney, suite 212

State Registrar

31. Date filed (Month, Day, Year): NOV 20 1998
32. Registrer's Signeture: Geneva G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: Tha law requires that tha death certificate be executed within 24 hours after death.
To the Funeral Director: Aftar this certificate has been signed by tha attending physician and completely filled in by tha funaral director, page 2 should be detached for usa as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

5

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37216

Physician / Medical Examiner

1. Decedent's Name (First, Middle, Last): ELMER PRESTON DICKERSON SR.
2. Date of Death (Month, Day, Year): NOVEMBER 20, 1998
3. Time of Death: 08:25
4a. Facility Name (If not institution, give street and number): JOHNS HOPKINS HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE CITY
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 224-28-8409
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 79 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 08/21/19
9. Birthplace (State or Foreign Country): VA

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 2209 Westwood Avenue
10f. Zip Code: 21216
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: 1943-45
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 5th — College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Equipment Operator
16b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): Douglas Dickerson
18. Mother's Name (First, Middle, Maiden Surname): Maggie Northan

19a. Informant's Name/Relationship (Type, Print): Lula Dickerson/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P. O. Box 234, Mappsville, VA 23407

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Odd Fellows Cemetery — Date: 11/28/98
20c. Location - City or Town, State: Accomac, VA

21. Signature of Funeral Service Licensee: Samuel R. Cooper Jr.
22. Name and Address of Facility: COOPER & HUMBLES FUNERAL CO., INC. P. O. Box 176, Accomac, VA 23301

Physician / Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. ADULT RESPIRATORY DISTRESS SYNDROME — 2 weeks.
Due to (or as a consequence of): b. SEPSIS — 2weeks.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
Due to (or as a consequence of): c.
Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Susan Mani MD
29c. License number: RES-000
29d. Date signed (Month, Day, Year): NOVEMBER 20, 1998

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): SUSAN MANI JOHNS HOPKINS HOSPITAL

State Registrar

31. Date filed (Month, Day, Year): NOV 25 1998
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37217

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Alfred William Dennis

2. Data of Death — Month: November Day: 7, Year: 1998

3. Time of Death: 1819

4a. Facility Name (If not institution, give street and number): University of Maryland Medical System

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 578-36-1100

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 70 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): October 11, 1928

9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: Delaware

10b. County: Sussex

10c. City, Town or Location: Seaford

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 630 N. Willey Street

10f. Zip Code: 19973

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1946-1953

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4 or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Vice President

16b. Kind of Business/Industry: Mill Work and Distribution

17. Father's Name (First, Middle, Last): David Dennis

18. Mother's Name (First, Middle, Maiden Surname): Frances Cornwell

19a. Informant's Name/Relationship (Type, Print): M.J. Dennis / wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 630 N. Willey Street, Seaford, Delaware 19973

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Parklawn Memorial Park Date: November 11, 1998

20c. Location - City or Town, State: Rockville, Maryland

21. Signature of Funeral Service Licensee: Barbara J. McMullen Lawrence M00831

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Multi organ Failure — 2 Days

Due to (or as a consequence of):

b. Pancreatitis — 3 Days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Airway Disease

Hypertension

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death (Check only one) Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: P12767

29d. Date signed (Month, Day, Year): November 7, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Khadi F. Udobi, MD 22 South Greene Street Baltimore, Md. 21201

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): NOV 16 1998

32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37218

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Rosemary Farrell Dunkin

2. Date of Death — Month: November; Day: 13; Year: 1998

3. Time of Death: 5:35 PM

4a. Facility Name *(If not institution, give street and number)*: Carriage Hill Bethesda

4b. City, Town, or Location of Death: Bethesda

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 472-24-5713

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 71 Yrs.

If Under 1 Year — Months: ; Days: ; If Under 24 Hrs. — Hours: ; Min.:

8. Date of Birth *(Month, Day, Year)*: July 27, 1927

9. Birthplace *(State or Foreign Country)*: Iowa

Usual Residance of Dacedant

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Locafion: Bethesda

10d. Inside City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 5405 Ridgefield Road

10f. Zip Coda: 20816

10g. Citizan of What Country?: United States

11. Marifal Stafus: 1☐ Naver Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedanf Evar in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yas, Giva Year or Datas:

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puarto Ricen, atc.) 1☐ Yas 2☒ No *Specify:*

14. Race - Amarican Indian, Black, Whita, efc. *Specify:* White

15. Decedant's Educafion *(Specify only highast grade completed)*: Elamentary/Secondary (0-12): ; College (1-4or 5+): 4

16a. Decedanf's Usual Occupation *(Giva kind of work dona during most of working life. DO NOT use ratired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Fathar's Nama *(First, Middla, Last)*: Thomas Farrell

18. Mothar's Nama *(First, Middla, Maiden Surname)*: Mary Casey

19a. Informant's Name/Ralationship *(Type, Print)*: Susan D. Orenduff / daughter

19b. Mailing Address *(Straat and Number or Rural Routa Number, City or Town, State, Zip Coda)*: P.O. Box 177 (7226 Spring Hill Farm), Hanover, Virginia 23069-0177

20a. Mathod of Disposition: 1☐ Burial 2☒ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Nama of cemetery, cramatory or othar place)*: Montgomery Crematorium, Inc. Data: November 17, 1998

20c. Location - City or Town, State: Bethesda, Maryland

21. Signafura of Funaral Sarvice Licansaa: Barbara J. McMullan Lawrence M00831

22. Nama and Address of Facility: Robert A. Pumphrey Funeral Home / Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that ceusad tha daath. Do not antar tha moda of dying, such as cardiac or raspiretory arrast, shock, or haart failura. List only ona causa on aach lina.

		Approximate Interval Betwaan Onset and Death
Immediata Causa (Final disaasa or condition resulting in death) a.	Non Small Cell Lung Cancer	18 Months
Dua to (or as a consequanca of): b.	Emphysema	10 Years
Sequentially list conditions, if any, laading to immadiafe causa. Entar Underlying Ceusa (Diseese or injury that initiated avants rasulting in daath) Last — Due to (or es a consequance of): c.	Congestive Heart Failure	9 Years
Due fo (or es e consequenca of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceusa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performad? 1☐ Yas 2☒ No

24b. Wara autopsy findings availabla prior to completion of causa of deafh? 1☐ Yas 2☐ No

25. Was cesa rafarrad to madical examinar? 1☐ Yas 2☒ No

26. Place of Death *(Chack only ona)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpatiant 3☐ DOA; Othar: 4☒ Nursing Homa 5☐ Rasidance 6☐ Othar *(Specify)*

27. Mannar of Death: 1☒ Natural 2☐ Accidanf 3☐ Suicida 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be determinad

28a. Data of Injury *(Month, Day Yaar)*

28b. Tima of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At homa, farm, straat, factory, office building, atc. *(Spacify)*

28f. Location *(Streat and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To tha bast of my knowledga, daath ocurrad at tha tima, data and placa, and dua to the cause(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, date and place, and dua to tha causa(s) and manner steted.

29b. Signafure and fifle of certifiar: Brian C Turrisi MD

29c. Licanse number: D24328

29d. Date signed *(Month, Day, Year)*: November 16, 1998

30. Name and addrass of person who complatad ceusa of deafh (Item 23e) (Type, Print): Brian Charles Turrisi, M.D. 2440 M Street, NW, #810, Washington, DC 20037-1404

State Registrar

31. Date filed *(Month, Day, Yaar)*: NOV 17 1998

32. Registrar's Signafure: Geneva G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37219

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARY P. DYRKACZ

2. Dete of Deeth — Month: NOV. Day: 12, Year: 1998

3. Time of Death: 12:49 AM

4e. Facility Name (If not institution, give street and number): ROCKVILLE NURSING HOME

4b. City, Town, or Location of Death: ROCKVILLE

4c. County of Deeth: MONTGOMERY

Funeral Director

5. Social Security Number: 190-01-5028

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 86 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Day, Yeer): NOV. 9, 1912

9. Birthplece (Stete or Foreign Country): PA.

Usual Residenca of Decadent

10a. State: MD.

10b. County: MONTGOMERY

10c. City, Town or Location: SILVER SPRING

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 15422 BRAMBLEWOOD DR.

10f. Zip Code: 20906

10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indien, Bleck, White, etc. Specify: WHITE

15. Decadent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12 College (1-4or 5+):

16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): ANALYST AND LINGUIST

16b. Kind of Business/Industry: NATIONAL SECURITY AGENCY

17. Fether's Neme (First, Middle, Last): WASYL PITUCH

18. Mother's Name (First, Middle, Maiden Surname): EVA CAPP

19a. Informent's Neme/Relationship (Type, Print): JOHN A. DYRKACZ/SON

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 1806 ELK RUN CT., OAK RIDGE, N. CAROLINA 27310

20a. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Pleca of Disposition (Neme of cemetery, crematory or other piece): CHAMBERS CREMATORY

Date: 11/13/98

20c. Location - City or Town, State: RIVERDALE, MD.

21. Signeture of Funeral Servica Licensee: W.W. Chambers M000091

22. Name end Address of Facility: CHAMBERS FUNERAL HOMES, P.A., SILVER SPRING, MD. 20910

To Be Completed by Funeral Director

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one ceuse on eech line.

Approximate Intervel Between Onset end Death

Immediate Cause (Final diseese or condition resulting in death)

a. sepsis

Due to (or as e consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury thet initiated events resulting in death) Lest

b. pneumonia

Due to (or as e consequenca of):

c.

Due to (or es e consequenca of):

d.

Part II. **Other eignificent conditione** contributing to death but not resulting in the undertying cause given in Pert I.

hypoalbuminemia

23b. Did tobacco use contribute to the ceuse of deeth? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☑ No

24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☑ No

26. Place of Deeth (Check only one) — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Deeth: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Placa of Injury - At home, ferm, street, factory, offica building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physicien:** To the best of my knowledge, death occurred et the time, dete end pleca, end due to the ceuse(s) and menner es steted. 2☐ **Medical Exeminer:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) and manner stated.

29b. Signature end title of certifier: David A. Blass MD

29c. License number: D23911

29d. Date signed (Month, Day, Year): November 12, 1998

30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print): David A. Blass MD 9410 Old Georgetown Rd. Bethesda, Md. 20814

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Dete filed (Month, Day, Year): NOV 16 1998

32. Registrer's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend #22,11/17/98,BMW,Montg.Co.

Certificate of Death

Reg. No. 98 37220

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
PETER - DOMARUK	NOVEMBER 12, 1998	11:20 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
4520 WINDSOR LANE	BETHESDA	MONTGOMERY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
577 60 9185	1☒M 2☐F	81 Yrs.			FEB.22,1917	UKRAINE

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.	MONTGOMERY	BETHESDA	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
4520 WINDSOR LANE	20814	UNITED STATES

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	0	LANDSCAPER	LANDSCAPING

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
PHILIP DOMARUK	ALEXANDRA YANOSEVITZ

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
PETER I. DOMARUK, SON	19104 WILLOW GROVE ROAD, OLNEY, MD. 20832

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	GATE OF HEAVEN CEMETERY	11/16/98	SILVER SPRING, MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Muriel H. Barber	MURIEL H. BARBER FUNERAL HOME P.O. ~~BOX~~ 5038, LAYTONSVILLE, MD. 20882

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

BMW

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Arteriosclerotic cardiovascular disease	6 years
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dementia, Alzheimer's type

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒Yes 2☐No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature]	D 21531	NOVEMBER 12, 1998

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
DR. G. PETER PUSHKAS, 11510 OLD GEORGETOWN ROAD, ROCKVILLE, MD. 20852

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 17 1998	[signature] G. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37221

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOHNNIE AUGUSTA DEXTER
2. Date of Death: Month NOV Day 16 Year 1998
3. Time of Death: 00:05 AM
4a. Facility Name (If not institution, give street and number): Golden Oak Nursing Home
4b. City, Town, or Location of Death: Laurel
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 235-20-9160
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 14, 1910
9. Birthplace (State or Foreign Country): Alix, Arkansas

Usual Residence of Decedent

10a. State: West Virginia
10b. County: Marion
10c. City, Town or Location: Fairmont
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1324 Pennsylvania Avenue
10f. Zip Code: 26554
10g. Citizen of What Country? United States of America

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Clerk
16b. Kind of Business/Industry: Retail Sales

17. Father's Name (First, Middle, Last): John Tims
18. Mother's Neme (First, Middle, Maiden Surname): Sarah Elizabeth Cruson

19a. Informant's Name/Relationship (Type, Print): Mary Hoffman /Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8304 Darkwood Court, Jessup, Maryland 20794

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other piece): Garndview Memorial Gardens | Date: November 19,1998
20c. Location - City or Town, State: West Fairmont, Virginia

21. Signature of Funeral Service Licensee: ▶ Howard A. Carson
22. Name and Address of Facility: Carpenter & Ford Funeral Home, 209 Merchant Street, Fairmont, West Virginia

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finel disease or condition resulting in death) a.	Acute stroke	Days
Due to (or as a consequence of):		
Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.	Acute myocardial infarction	Days
Due to (or as a consequence of):		
c.	Coronary artery disease	Years
Due to (or es e consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: CHF

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]
29c. License number: D28998
29d. Date signed (Month, Day, Year): NOV 16 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PRITAM S SAINANI, 9101 CHERRY LN #211, Laurel MD 20708

State Registrar

31. Date filed (Month, Day, Year): NOV 19 1998
32. Registrar's Signature: Deputy G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37222

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Jan Richardson DeRoide
2. Date of Death Month Day Yeer: November 12, 1998
3. Time of Death: 7:30 a.m.

4a. Facility Name *(If not institution, give street and number)*: 13237 Country Ridge Drive
4b. City, Town, or Location of Death: Germantown
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 258-02-3157
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 43 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Sept 28, 1955
9. Birthplace *(State or Foreign Country)*: Georgia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Germantown
10d. Inside City Limits: 1☐ Yes 2☐ No X
10e. Street and Number: 13237 Country Ridge Drive
10f. Zip Code: 20874
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Housewife
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Richard Richardson
18. Mother's Name *(First, Middle, Maiden Surname)*: Elizabeth Lee

19a. Informant's Name/Relationship *(Type, Print)*: John DeRoide, Husband
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 13237 Country Ridge Drive, Germantown, MD 20874

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metropolitan Crematory
Date: Nov. 14 1998
20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: Gary M. Irvin
22. Name and Address of Facility: DeVol Funeral Home, 10 East Deer Park Dr., Gaithersburg, MD. 20877

BMW

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, ahock, or heert feilure. List only one cause on each line.

Approximate Intervel Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Emphysema — years

Due to (or as e consequence of):
b. alpha-one-antitrypsin deficiency — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as e consequenca of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cauae of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was cese referred to medicel examiner? 1☒ Yes 2☐ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end piece, end due to the cause(s) and manner es steted. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: Alan S Chanales MD
29c. License number: D29453
29d. Date signed *(Month, Day, Year)*: November 12, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Alan S. Chanales, M.D., 15225 Shady Grove Road, Rockville, Maryland 20850

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 16 1998
32. Registrar's Signature: Geneva G. Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

To be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

+ Released by M.E. 11/12/98 +

Medical Certification: To Be Completed by Physician/Medical Examiner

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DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 37223

Amend #29d,11/16/98,BMW,Montg.Co/per physician *Certificate of Death*

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Margaret Mary DeMarco
2. Date of Death (Month, Dey, Year): Nov.10,1998
3. Time of Death: 1:30 AM
4a. Facility Name (If not institution, give street and number): National Lutheran Home
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 578-14-8863
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Yeer): June 21,1913
9. Birthplece (State or Foreign Country): Wash.,D.C.

Usuel Residence of Decedent

10a. State: none
10b. County: none
10c. City, Town or Location: Washington, D.C.
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street end Number: 3829 Beecher St.,N.W.
10f. Zip Code: 20007
10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Bleck, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 4
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): homemaker
16b. Kind of Business/Industry: own home

17. Father's Name (First, Middle, Last): Harry Murray
18. Mother's Name (First, Middle, Maiden Surneme): Gertrude Fletcher

19a. Informent's Name/Relationship (Type, Print): Joseph DeMarco/son
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 14929 Emory Lane, Rockville, Md. 20853

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Piace of Disposition (Neme of cemetery, cremetory or other piece): Mt. Olivet Cemetery | Dete: Nov.13,98
20c. Location - City or Town, State: Washington,D.C.

21. Signature of Funeral Service Licensee: John F. DeVol
22. Name end Address of Facility: DeVol Funeral Home 2222 Wisconsin Ave.,N.W.,Wash.,DC 20007

BMW

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failure. List only one ceuse on eech line.

		Approximete Intervel Between Onset end Death
Immediete Ceuse (Finel diseese or condition resulting in deeth) e.	Sudden Cardiac Death	minutes
Due to (or es e consequence of):		
Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Ceuse (Disease or injury thet initieted events resulting in deeth) Lest b.	Congestive Heart Failure	years
Due to (or es e consequence of):		
c.	Atherosclerosis	year
Due to (or es e consequence of):		
d.		

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Diabetes Mellitus, type II; Alzheimers Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Piece of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)
28b. Time of Injury
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Phyeician:** To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, date and piece, end due to the cause(s) and menner steted.

29b. Signeture end title of certifier: MD
29c. License number: D33138
29d. Date signed (Month, Day, Year): ~~11-10-98~~ November 10-1998

30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print): Daniel A Jaller MD 12850 Middlebrook Rd, Germantown, MD

State Registrar

31. Dete filed (Month, Day, Year): NOV 16 1998
32. Registrer's Signeture: G. Sparks

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37224

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Haile Tesfamariam Daniel

2. Dete of Deeth — Month: Nov; Dey: 15; Yeer: 1998

3. Time of Death: 01:00 PM

4e Fecility Neme *(If not institution, give street end number)*: Holy Cross Hospital

4b. City, Town, or Location of Deeth: Silver Spring

4c. County of Deeth: Montgomery

Funeral Director

5. Social Security Number: None

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. lest birthday)*: Yrs.

If Under 1 Year: Months; Deys

If Under 24 Hrs.: Hours: 2; Min.

8. Date of Birth *(Month, Dey, Yeer)*: NOV 15 1998

9. Birthplece *(Stete or Foreign Country)*: Maryland

Usuel Residence of Decedent

10e. Stete: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street end Number: 48 Kinsman View Circle

10f. Zip Code: 20901

10g. Citizen of Whet Country?: United States

11. Maritel Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Detes:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indien, Bleck, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grede completed)*: Elementary/Secondary (0-12): 0; College (1-4or 5+):

16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: NONE

16b. Kind of Business/Industry: N/A

17. Father's Neme *(First, Middle, Last)*: Daniel Tesfamariam

18. Mother's Name *(First, Middle, Maiden Surname)*: Nebiat Eyassu

19a. Informent's Name/Reletionship *(Type, Print)*: Daniel Tesfamariam (Father)

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: Same as 10

20e. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Chesapeake Crematory

Date: 11-19-98

20c. Location - City or Town, State: Beltsville, Maryland

21. Signature of Funeral Service Licensee: Eileen H. Rapp

22. Name end Address of Fecility: Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, Maryland

DMW

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Deeth

Immediate Ceuse (Final disease or condition resulting in death): e. Severe Prematurity

Due to (or es e consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in death) Lest:

b. Due to (or es e consequence of):

c. Due to (or es e consequence of):

d.

Pert II. **Other significent conditione** contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. Did tobecco use contribute to the cauee of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24e. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Piece of Deeth *(Check only one)*: Hospital: 1 [X] Inpetient 2 [ ] ER/Outpetient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Deeth: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigetion 6 [ ] Could not be determined

28e. Dete of Injury *(Month, Dey Yeer)*

28b. Time of Injury M

28c. Injury et Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, offica building, etc. *(Specify)*

28f. Location *(Street and Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Phyeician:** To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner es steted. 2 [ ] **Medical Examiner:** On the besis of examination end/or investigation, in my opinion, death occurred et the time, date end pleca, end due to the cause(s) and manner stated.

29b. Signature end title of certifier: Paul E. Lewis MD

29c. License number: D35007

29d. Date signed *(Month, Dey, Yeer)*: 11/18/98

30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print): Paul E. Lewis, M. D., 1500 Forest Glen Road, Silver Spring, MD 20910

State Registrar

31. Date filed *(Month, Dey, Yeer)*: NOV 19 1998

32. Registrer's Signeture: Lenora G. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37225

Physician /Medical Examiner

1. Decedent's Nama *(First, Middle, Last)*: Helen F. DeLany

2. Data of Death — Month: November; Day: 16; Year: 1998

3. Tima of Death: 1:56 PM

4a Facility Nama *(If not institution, give street and number)*: Montgomery General Hospital

4b. City, Town, or Location of Death: Olney

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-20-0655

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 99 Yrs.

If Under 1 Year — Months: ; Days: ; If Under 24 Hrs. — Hours: ; Min.:

8. Data of Birth *(Month, Day, Year)*: Oct. 9, 1899

9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residance of Decedant

10a. Stata: MD

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3701 International Drive, Apt.259

10f. Zip Code: 20906

10g. Citizan of What Country?: USA

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yas, Giva Yaer or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 1☐ Yas 2☒ No *Specify:*

14. Race - American Indian, Black, Whita, atc. *Specify:* White

15. Decedent's Education *(Specify only highast grada compiated)* — Elementary/Secondary (0-12): ; Collega (1-4or 5+): 1

16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT use retired)*: Dental Hygienist

16b. Kind of Businass/Industry: Dental

17. Fathar's Name *(First, Middle, Last)*: Thomas F. Fitzsimmons

18. Mother's Name *(First, Middle, Maidan Sumama)*: Anna Barry

19a. Informant's Name/Ralationship *(Type, Print)*: Jere T. DeLany (son)

19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 7406 Rodney Court, Cincinnati, OH 45241

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramovel from State 4☐ Donation 5☐ Othar *(Specify)*

20b. Place of Disposition *(Nama of cematary, crematory or othar place)*: Gate of Heaven Cemetery

Date: 11/21/98

20c. Location - City or Town, Stata: Silver Spring, MD

21. Signeture of Funaral Sarvice Licensee: James E Dooley

22. Nama and Addrass of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

DMH

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complications that caused tha daath. Do not entar tha moda of dying, such as cardiac or raspiratory errest, shock, or haart failura. List only one ceuse on each line.

Approximata Interval Between Onset and Death

Immediata Causa (Final disease or condition resulting in death)

a. Acute Myocardial Ischemia — HOURS

Dua to (or as a consequance of):

Sequantially list conditions, if any, leeding to immadiata cause. Enter Undarlying Cause (Disaasa or injury that initiated evants resulting in death) Last

b. — Dua to (or as a consequence of):

c. — Dua to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Ware autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes casa rafarrad to medical examiner? 1☐ Yas 2☒ No

26. Piece of Deeth *(Check only ona)* — Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Homa 5☐ Residence 6☐ Othar *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accidant 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Data of Injury *(Month, Day Year)*

28b. Tima of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, office building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)* 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the tima, date and place, and due to the causa(s) and manner as stated. 2☐ **Medical Examiner:** On tha basis of examination and/or investigation, in my opinion, daath occurred at the time, date and piece, and dua to the cause(s) and mannar stated.

29b. Signeture and title of certifier: Gabriel A Berrebi MD

29c. License number: B30692

29d. Data signed *(Month, Day, Year)*: November 17, 1998

30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print): Gabriel A. Berrebi, M.D. 15200 Shady Grove Road, Rockville, MD 20850

State Registrar

31. Dete filed *(Month, Day, Year)*: NOV 19 1998

32. Registrar's Signatura: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DELANY, HELEN

35

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37226

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Dorothy Phyllis Dodson

2. Data of Death: Month November Day 16 Year 1998

3. Time of Death: 4:30 A

4a. Facility Name (If not institution, give street end number): North Arundel Hosp

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 212-24-3810

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 69 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 21, 1929

9. Birthplace (State or Foreign Country): Maryland

Usual Residance of Decedent

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Severn

10d. Inside City Limits: 1☒ Yes 2☐ No

10a. Street and Number: 7905 Stone Hearth Road

10f. Zip Code: 21144

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Naver Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): Grade 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Nama (First, Middle, Last): Theodore Roosevelt Merson

18. Mother's Name (First, Middle, Maiden Sumema): Helen Mae Johnson

19a. Intormant's Name/Relationship (Type, Print): Jack O. Dodson /spouse

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 7905 Stone Hearth Road, Severn, Maryland 21144

20a. Method ot Disposition: 1☒ Burial 2☐ Cremation 3☐ Ramoval from Stata 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Neme of cematery, cremetory or other place): Ivy Hill Cemetery

Date: 11/19

20c. Location - City or Town, Stata: Laurel, Maryland

21. Signature of Funeral Service Licensee: Donald Donaldson

22. Name and Address of Facility: Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707-4389

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset end Deeth

Immadiate Cause (Final disease or condition resulting in deeth) a. Acute myocardiac Infarction 2 Days

Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last

b. Dua to (or es e consequence ot):

c. Dua to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobecco usa contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy tindings available prior to completion of cause of deeth? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Piece of Death (Check only one): Hospital: 1☒ Inpatiant 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date ot Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, tactory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best ot my knowledge, death occurred et the time, date and place, end due to the ceuse(s) end manner as stated. 2☐ **Medical Examiner:** On the basis ot examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature end title of certitier: MD

29c. License number: D48006

29d. Date signed (Month, Dey, Year): November 16, 1998

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): KOFI OWUSU-BOAITEY, 301 HOSP DR, GLEN BURNIE, MD

State Registrar

31. Date filed (Month, Day, Year): NOV 19 1998

32. Registrar's Signeture: Denise G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Dorothy Dodson

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37227

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ethel R. DAMMYER

2. Date of Death (Month, Dey, Yeer): November 17 1998

3. Time of Death: 945 pm

4a. Facility Name (If not institution, give street end number): St. Agnes Nrsg Ctr. 3000 N. Ridge Rd

4b. City, Town, or Location of Death: Ellicott City

4c. County of Death: Md. HOWARD

Funeral Director

5. Social Security Number: 216-01-3556

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 83 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Year): Oct 17, 1915

9. Birthplece (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Howard

10c. City, Town or Location: Ellicott City

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 2863 Country Lane

10f. Zip Code: 21042

10g. Citizen of Whet Country?: United States

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - Americen Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondery (0-12): 10

College (1-4or 5+):

16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Neme (First, Middle, Last): Milton Seward

18. Mother's Name (First, Middle, Maiden Surneme): Lettie Claggett

19a. Informent's Name/Relationship (Type, Print): Darlene Grund/Daughter

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 2863 Country Lane Ellicott City, MD 21042

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donetion 5☐Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other place): Mt Zion Cemetery

Date: 11-20-98

20c. Location - City or Town, State: Freeland, Maryland

21. Signeture of Funeral Service Licensee: Karen a Collins-Witzke

22. Name end Address of Facility: Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043

Physician /Medical Examiner

23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Deeth

Immediate Ceuse (Finel disease or condition resulting in death)

e. SEPSIS — 1 week

Due to (or es e consequence of):

Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury thet initieted events resulting in deeth) Lest

b. RIGHT FOOT GANGRENE

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Part I.

DEMENTIA.

HYPERTENSION

23b. **Did tobacco use contribute to the cause of death?** 1☐Yes 2☐No 3☐Probably 4☑Unknown

24a. Wes en eutopsy performed? 1☐Yes 2☑No

24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1☐Yes 2☑No

25. Was case referred to medical examiner? 1☐Yes 2☑No

26. Piece of Death (Check only one)

Hospitel: 1☐Inpetient 2☐ER/Outpetient 3☐DOA

Other: 4☑Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☑Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigation 6☐Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury

28c. Injury et Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, offica building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑**Certifying Phyeician:** To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted. 2☐**Medical Examiner:** On the besis of examination end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end menner steted.

29b. Signeture end title of certifier: Tasneem Lakhani

29c. License number: D28595

29d. Date signed (Month, Dey, Yeer): 11/18/98

30. Neme end eddress of perso who completed cause of death (Item 23e) (Type Print): TASNEEM LAKHANI, 7220 PARK HEIGHTS AVE BALTO MD 21208

State Registrar

31. Dete filed (Month, Day, Year): NOV 19 1998

32. Registrer's Signeture: Bonnie G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "neturel", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

6

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37228

BLANCHE DIXSON

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Blanche Virginia Ely Dixson

2. Date of Death: Month Nov, Day 22, Year 1998

3. Time of Death: 8:43 AM

4a. Facility Name (If not institution, give street and number): Civista Medical Center

4b. City, Town, or Location of Death: LaPlata

4c. County of Death: Charles

Funeral Director

5. Social Security Number: 579-07-7113

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.

8. Date of Birth (Month, Day, Year): Nov. 27, 1916

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Clinton

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 6204 Buckler Road

10f. Zip Code: 20735

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elamantary/Secondary (0-12): 12th; College (1-4or 5+): N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Accounts Receivalbe

16b. Kind of Business/Industry: PEPCO

17. Father's Name (First, Middle, Last): Harry Kirk Ely, Sr.

18. Mother's Neme (First, Middle, Maiden Surname): Elsie Billingsley

19a. Informant's Name/Relationship (Type, Print) (Niece): Virginia Ely Townshend

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1651 Clarketown Rd. Heathsville VA 22473

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Ft. Lincoln Cemetery; Date: Nov. 25, 1998

20c. Location - City or Town, State: Brentwood, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name end Address of Facility: Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd Clinton, MD 20735

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line.

Approximete Intervel Batween Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Papillary Carcinoma of Thyroid

Due to (or as a consequanca of):
b. Multiple Myeloma

Sequantially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disaasa or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as e consequence of):
d.

Part II. **Other signifcant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Status permanent Tracheostomy

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examinar? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatiant 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding investigation 6☐ Could not be datarmined

28a. Data of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28a. Placa of Injury - At home, farm, streat, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the **Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
To the **Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Cartifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledga, death occurred at the time, date and placa, and due to the cause(s) and mannar as statad. 2☐ **Medical Examiner:** On the basis of examination and/or Investigation, In my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] M.D.

29c. License number: D-37174

29d. Date signed (Month, Day, Year): 11/22/98

30. Name and address of person who complated ceuse of death (Item 23a) (Type, Print): Song C. Chon, MD; Cenna Medical Center, 7C Post Office Rd Waldorf, Maryland 20602

30

State Registrar

31. Date filed (Month, Day, Year): NOV 25 1998

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37229

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): VASILIKI EFTHEMEOS EFANTIS
2. Date of Death: Month NOV. Day 9, Year 1998
3. Time of Death: 9:35 AM
4a. Facility Name (If not institution, give street and number): CITIZENS NURSING HOME
4b. City, Town, or Location of Death: FREDERICK
4c. County of Death: FREDERICK

Funeral Director

5. Social Security Number: 578-40-7782
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 92 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): AUG. 17, 1906
9. Birthplace (State or Foreign Country): GREECE

Usual Residence of Decedent

10a. State: MD.
10b. County: FREDERICK
10c. City, Town or Location: NEW MARKET
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 10431 OLD NATIONAL PIKE
10f. Zip Code: 21774
10g. Citizen of What Country?

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SEAMTRESS
16b. Kind of Business/Industry: WOODROW & LOTHROPE

17. Father's Name (First, Middle, Last): EFTHEMEOUS E. PAPANKHOLES
18. Mother's Name (First, Middle, Maiden Surname): UNKNOWN

19a. Informant's Name/Relationship (Type, Print): EFTHEMEOS EFANTIS (SON)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10431 OLD NATIONAL PIKE NEW MARKET MARYLAND 21774

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): FORT LINCOLN CEMETERY
Date: NOV. 13, 1998
20c. Location - City or Town, State: BRENTWOOD MARYLAND

21. Signature of Funeral Service Licensee: Keith Lackey
22. Name and Address of Facility: HINES RINALDI FUNERAL HOME MD. 20904 11800 NEW HAMPSHIRE AVE. SILVER SPRINGS

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Ceuse (Finel diseasa or condition rasulting in death) a.	Pneumonia	2wks
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last b.	Severe Dementia	5 yrs.
Due to (or as a consequence of):		
c.		
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Anemia due to Thallassemia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Jane S. Griffith MD
29c. License number: D21944
29d. Date signed (Month, Day, Year): 11/11/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jane S. Griffith MD. 300 W 9th St. Frederick Md. 21701

State Registrar

31. Date filed (Month, Day, Year): NOV 16 1998
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

98-6525-031

B.K.S

NELSON NOEL FRANCIS
ITEMS: #23 PART I, 27, 28A-F PER MEO G766 12-7-98 WR

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

98 37230

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Nelson Noel Francis	NOV. 9, 1998	1750 PM

4a Facility Name (If not institution, give street end number)	4b. City, Town, or Location of Death	4c. County of Death
SHADY GROVE ADVENTIST HOSPITAL E.R.	ROCKVILLE	MONTGOMERY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
022-56-0173	1☒ M 2☐ F	35 Yrs.			January 15, 1963	Maine

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Gaithersburg	1☐ Yes 2☒ No

10e. Street end Number	10f. Zip Code	10g. Citizen of What Country?
8917 Blue Smoke Drive	20879	United States

11. Marital Status	12. Was Decedent Ever In U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indien, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: Native American

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10		Self Employed	Home Improvements

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Meiden Surneme)
William Avery	Martha Sock

19a. Informant's Name/Reletionship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mary Elizabeth Sullivan/ Wife	8917 Blue Smoke Drive Gaithersburg,Maryland 20879

20a. Method of Disposition	20b. Placa of Disposition (Name of cemetery, cremetory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Montgomery Crematorium Inc.	November 16,1998	Bethesda, Maryland

21. Signature of Funeral Service Licensee	22. Name end Address of Facility
▶ [signature] M00335	Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Dmd

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heert failure. List only one cause on eech line.

		Approximate Intervel Between Onset and Death
Immediate Cause (Finel diseese or condition resulting in death)	a. ACUTE ETHANOL AND PROPOXPHENE INTOXICATION	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequenca of):	
	c.	
	Due to (or as e consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings aveilable prior to completion of cause of death?
1☒ Yes 2☐ No	1☒ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
☒ Yes 2☐ No	Hospitel: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other (Specify)

27. Manner of Deeth	28e. Dete of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☒ Could not be determined	Found: 11-9-98	UNKNOWN M	1☐ Yes 2☒ No	UNKNOWN

28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
FOUND AT HOME	8543 HAWK RUN TER. GAITHERSBURG, MARYLAND

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete and piece, and due to the cause(s) and menner es steted.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) end manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Dennis J. Chute MD	O.C.M.E	NOV. 10, 1998

30. Name and address of person who completed cause of deeth (Item 23e) (Typa, Print)
Dennis J. Chute MD 111 Penn Street, Baltimore, Maryland 21201

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 17 1998	[signature] G. Sparks

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37231

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James H. Foltz

2. Date of Death: Month November Day 7, Year 1998

3. Time of Death: 12:50 PM

4e. Facility Name (If not institution, give street and number): Montgomery Village Care & Rehabilitation

4b. City, Town, or Location of Death: Montgomery Village

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 204-14-1718

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 72 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): April 4, 1926

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Kensington

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 10215 Parkwood Drive

10f. Zip Code: 20895

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No. If Yes, Give Year or Dates: WW II Korea

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Engineer

16b. Kind of Business/Industry: U.S. Government

17. Father's Name (First, Middle, Last): James Clarence Foltz

18. Mother's Name (First, Middle, Maiden Surname): Leone Hollman

19a. Informant's Name/Relationship (Type, Print): Marion E. Foltz/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10215 Parkwood Drive, Kensington, Maryland 20895

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Montgomery Crematorium, Inc. Date: Nov. 17, 1998

20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service Licensee: Ronald Funk M00198

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Congestive heart failure

Due to (or as a consequence of):
b. Coronary artery disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Hypertensive arteriosclerotic

Due to (or as a consequence of):
d. cardiovascular disease

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Cellulitis/abscess of leg
Diabetes, type I, with
bilateral amputations
Old stroke Seizure disorder

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: H. Robert Birschbach, M.D.

29c. License number: 04115

29d. Date signed (Month, Day, Year): November 7, 1998

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): H. Robert Birschbach, M.D. 6320 Democracy Blvd., Bethesda, Maryland 20817

State Registrar

31. Date filed (Month, Day, Year): NOV 16 1998

32. Registrar's Signature: Geneva D. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37232

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month / Day / Year	3. Time of Death
BENJAMIN	FRANK	November 12, 1998	12:36 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
SHADY GROVE ADVENTIST HOSPITAL	ROCKVILLE	MONTGOMERY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
182-10-7451	1☒M 2☐F	83 Yrs.			Dec. 25, 1914	Pennsylvania

Usual Residence of Decedent

10a. Stete	10b. County	10c. City, Town or Location	10d. Inside City Limits
Pennsylvania	Philadelphia	Philadelphia	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of Whet Country?
6605 Akron Street	19149	U.S.A.

11. Marital Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Raca - American Indian, Black, White, etc.
1☐Never Married 2☐Merried 3☒Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Detes: WWII	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10 Years		Benefits Counsellor	Veterans Administration

17. Fether's Neme (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Sumame)
Ezra Frank	Ethel (Unknown)

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code)
Inez Frank, Daughter	4801 Arctic Court, Rockville, Maryland 20853

20e. Method of Disposition	20b. Piece of Disposition (Name of cemetery, cremetory or other piece)	Date	20c. Location - City or Town, Stete
1☒Burial 2☐Cremetion 3☐Removal from State 4☐Donation 5☐Other (Specify)	Shalom Cemetery	November 13, 1998	Lower Moreland, Pennsylvania

21. Signature of Funerel Service Licensee: William A. Hall

22. Name and Address of Facility: STEIN HEBREW MEMORIAL FUNERAL HOME, INC. 232 CARROLL STREET, NW, WASHINGTON, DC 20012

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heert failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Sepsis	days
	Due to (or es a consequence of):	
Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest	b. Aspiration pneumonia	days
	Due to (or es e consequence of):	
	c.	
	Due to (or es a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uas contributs to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was en eutopsy performed?	24b. Were autopsy findings available prior to completion of cause of deeth?
1☐Yes 2☒No	1☐Yes 2☒No

25. Wes case referred to medical examiner?	26. Place of Deeth (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Deeth	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Naturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)	28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end manner stated.

29b. Signature end title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)
Patricia L. Tomsko, MD	D51916	November 12, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Patricia L. Tomsko, MD, 11140 Rockville Pike, #348, Rockville, MD 20852

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 16 1998	Jennie G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 37233

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Frances Isnook Fox

2. Data of Daath: Month November Day 19, Yaer 1998

3. Time of Death: 7:18AM

4a Facility Nema (If not institution, give street and number): 4618 Highland Avenue

4b. City, Town, or Location of Deeth: Bethesda

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 050-14-9549

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 90 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): Jun. 21, 1908

9. Birthplece (State or Foreign Country): New York

Usual Rasidence of Dacedant

10a. Steta: Maryland

10b. County: Montgomery

10c. Clty, Town or Location: Bethesda

10d. Insida City Limits: 1☐ Yas 2☒ No

10e. Street end Number: 4618 Highland Avenue

10f. Zip Code: 20814

10g. Citizan of Whet Country?: United States

11. Maritel Status: 1☐ Navar Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Wes Dacedent Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Giva Yaar or Dates: X

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Ricen, atc.) 1☐ Yes 2☒ No Specify:

14. Race - Amarican Indien, Black, White, etc. Specify: White

15. Decedent's Eaucetion (Spacify only highast grada complatad): Elementary/Secondary (0-12): College (1-4or 5+): 1

16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired): Owner

16b. Kind of Businass/Industry: Employment Agency

17. Fathar's Nama (First, Middla, Last): Jacob Isnook

18. Mothar's Name (First, Middle, Maidan Surnama): Clara Winograd

19a. Informant's Name/Relationship (Type, Print): Dena Rose Yver/Daughter

19b. Mailing Addrass (Straat and Numbar or Rural Routa Number, City or Town, State, Zip Coda): 4618 Highland Avenue, Bethesda, Maryland 20814

20a. Method of Disposition: 1☐ Burial 2☒ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Specify)

20b. Place of Disposition (Nama of cemafary, crematory or othar place): Montgomery Crematorium, Inc. Data: Nov. 20, 1998

20c. Location - City or Town, Stata: Bethesda, Maryland

21. Signatura of Funaral Service Licansee: David E. Perry. M00803

22. Nama and Addrass of Facility: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that caused tha daath. Do not anter tha moda of dying, such as cerdiac or respiratory arrast, shock, or heart failura. List only ona causa on aach lina.

Approximata Intarval Betwaen Onsat and Death

Immediata Causa (Final disaase or condition rasulting in daath)

a. Cerebrovascular Accident — 8 Hours

Dua to (or as a consequance of):

b. Atrial Fibrillation

Sequantially list conditions, if any, laading to immadiata ceusa. Entar Undarlying Ceuse (Diseasa or injury that Initiated events rasulting in death) Last

Dua to (or as a consequance of):

c.

Due to (or as e consaquence of):

d.

Part II. **Othar significant conditions** contributing to death but not resulting in tha undarlying ceusa givan in Part I.

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Wara autopsy findings available prior to complation of ceusa of death? 1☐ Yas 2☒ No

25. Was cesa rafarrad to madical examinar? 1☒ Yas 2☐ No

26. Placa ot Death (Check only one): Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA Othar: 4☐ Nursing Home 5☒ Rasidance 6☐ Othar (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding investigation 6☐ Could not be determined

28a. Data of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Cartifiar (Check only one): 1☒ **Certifying Physician:** To the best of my knowledga, daath occurred at tha tima, data and place, and dua to the cause(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, and dua to tha ceusa(s) and manner steted.

29b. Signature and titla of certifiar: Hubert J. Alpert

29c. Licansa number: D00143

29d. Data signed (Month, Day, Year): November 19, 1998

30. Nama and addrass of parson who completed ceusa of daath (Item 23a) (Type, Print): Hubert Alpert, M.D. 8630 Fenton Street, #230, Silver Spring, MD 20910-3892

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Data filad (Month, Day, Year): NOV 20 1998

32. Registrar's Signatura: Geneva G. Sparks

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37234

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Gordon Neal Firth	November 16, 1998	9:25 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
4947 Crescent Street	Chevy Chase	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-34-6918	1☒ M 2☐ F	62 Yrs.			October 15, 1936	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Chevy Chase	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
4947 Crescent Street	20815	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	1☒ Yes 2☐ No If Yes, Give Yeer or Detes: 1960-1966	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grede completed)		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	5+	Managing Editor	Publications

17. Fether's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Meiden Sumeme)
Neal V. Firth	Helen Zeitelhack

19a. Informent's Neme/Relationship (Type, Print)	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)
David C. Firth/Brother	225 Crossroads Blvd., Carmel, California 93923

20e. Method of Disposition	20b. Pleca of Disposition (Neme of cemetery, cremetory or other piece)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)	Montgomery Crematorium, Inc.	November 18, 1998	Bethesda, Maryland

21. Signature of Funeral Service Licentiate		22. Name and Address of Facility
▶ M. [illegible]	M00846	Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisonsin Avenue, Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiratory errest, shock, or heart failure. List only one cause on eech line.

		Approximete Interval Between Onset end Death
Immediate Cause (Finel disease or condition resulting in deeth)	e. Atherosclerotic Cardiovascular Disease	Years
	Due to (or es e consequence of):	
Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last	b. Due to (or es e consequenca of):	
	c. Due to (or es e consequence of):	
	d.	

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobecco use contribute to the ceuse of deeth? 1☐ Yes 2☐ No 3☐ Probebly 4☒ Unknown

24a. Wes en eutopsy performed?	24b. Were autopsy findings eveilable prior to completion of cause of deeth?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Wes case referred to medical examiner?	26. Piece of Deeth (Check only one)	
1☒ Yes 2☐ No	Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA	Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death	28e. Dete of Injury (Month, Dey Yeer)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☐ **Certifying Physicien:** To the best of my knowledge, death occurred et the time, date end place, end due to the ceuse(s) end menner es steted.
2☒ **Medical Examiner:** On the basis of examination end/or investigetion, in my opinion, deeth occurred et the time, dete end piece, end due to the cause(s) end manner stated.

29b. Signature end title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Patricia L. Tomsko, MD	D51916	November 18, 1998

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print)
Patricia L. Tomsko, M.D. 11140 Rockville Pike, #348, Rockville, Maryland 20852

State Registrar

31. Date filed (Month, Dey, Yeer)	32. Registrer's Signature
NOV 20 1998	[illegible] B. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend #7,11/16/98,BMW,,Montg. Co

Certificate of Death

Reg. No. 98 37235

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John Robert Falvella

2. Deta of Daath: Month NOVEMBER Dey 12, Year 1998

3. Time of Deeth: 11:15 pm

4a. Facility Neme (If not institution, give street and numbar): Brooke Grove Nursing Home

4b. City, Town, or Location of Deeth: Olney

4c. County of Daath: Montgomery

Funeral Director

5. Social Security Number: 108-18-4085

6. Sex: 1☒ M 2☐ F

7. Aga (In yrs. last birthdey): 73 ~~72~~ Yrs. If Under 1 Yaar: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Deta of Birth (Month, Dey, Year): Dec.17,1924

9. Birthplace (State or Foreign Country): New York

Usual Residance of Decedant

10a. Stata: Maryland

10b. County: Montgomery

10c. City, Town or Location: Rockville

10d. Inside City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 14601 Crossway Road

10f. Zip Code: 20853

10g. Citizen of Whet Country?: U.S.A.

11. Maritat Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedant Ever in U,S. Armed Forcas? 1☒ Yas 2☐ No. If Yes, Give Year or Detes: WWII

13. Wes Decedant ot Hispanic Orlgin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puarto Rican, atc.): 1☐ Yas 2☒ No Specify:

14. Race - American tndian, Black, White, atc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12); College (1-4or 5+): 4

16a. Decedent's Usuei Occupetion (Give kind of work done during most of working life. DO NOT use retired): Trust Administrator

16b. Kind of Business/Industry: Labor Relations

17. Father's Nema (First, Middle, Last): Joseph Falvella

18. Mother's Neme (First, Middle, Maidan Surneme): Mary Burke

19e. Informent's Neme/Reietionship (Type, Print): Mary H. Falvella (wife)

19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code): 14601 Crossway Road Rockville,Maryland 20853

20e. Mathod of Disposition: 1☒ Buriel 2☐ Cremation 3☐ Ramoval from Stete 4☐ Donetion 5☐ Othar (Specify)

20b. Piece of Disposition (Nema of cemetery, crametory or othar place): Gate of Heaven Cemetery

Data: 11/16/98

20c. Location - City or Town, Stete: Silver Spring,Maryland

21. Signeture of Funerel Service Licensee: L. Kevin Gutowski

22. Name end Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd.,W.,Silver Spring,MD 20901

Physician /Medical Examiner

23a. Pert1. Entar tha diseasa, or complications that cabsed tha daath. Do not entar tha moda of dying, such as cardiac or raspiratory arrest, shock, or heert teilure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Ceusa (Final disease or condition resulting in deeth):
a. ASPIRATION PNEUMONIA — 1 WEEKS

Due to (or as e consequance of):
b. DYSPHAGIA — MONTHS

Sequentially list conditions, if any, leeding to immadiate cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last:
c. ADVANCED DEMENTIA

Dua to (or es a consequance of):
d.

Pert ii. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert i.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yas 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings availabie prior to completion of cause of death? 1☐ Yes 2☒ No

25. Wes case referred to medical examinar? 1☐ Yas 2☒ No

26. Place ot Deeth (Check only one): Hospitel: 1☐ inpatient 2☐ ER/Outpatient 3☐ DOA. Other: 4☒ Nursing Homa 5☐ Rasidance 6☐ Othar (Specify)

27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending invastigation 6☐ Could not be determined

28a. Dete of tnjury (Month, Dey Year)

28b. Time of injury M

28c. injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, tactory, office building, atc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, dete end piece, end due to the cause(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end piece, end due to the cause(s) end menner steted.

29b. Signature and title of certifier: T. Howe MD

29c. License number: D33700

29d. Date signed (Month, Day, Year): NOVEMBER 13, 1998

30. Neme and eddress of person who completed cause of deeth (item 23e) (Type, Print): TED E. HOWE 7542 OVERLOOK DR. BOONSBORO, MD 21713

State Registrar

31. Dete filed (Month, Day, Yeer): NOV 16 1998

32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37236

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: VERONICA FORMULAK
2. Date of Death (Month, Day, Year): November 6, 1998
3. Time of Death: 1:20 am
4a. Facility Name *(If not institution, give street and number)*: Medlantic Manor
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 183-07-1895
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 87 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Nov 25, 1910
9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: PA
10b. County: Luzerne
10c. City, Town or Location: Glen Lyon
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 17 West Enterprise Street
10f. Zip Code: 18617
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): Grade 6 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Machine Operator
16b. Kind of Business/Industry: Garment

17. Father's Name *(First, Middle, Last)*: unavailable Wojtaszek
18. Mother's Name *(First, Middle, Maiden Surname)*: Ann unavailable

19a. Informant's Name/Relationship *(Type, Print)*: Lawrence Formulak / son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6 Coupler Court Stewartstown, Pa.

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: St. Adalberts Cemetery
Date: 11/9/98
20c. Location - City or Town, State: Glen Lyon, Pa.

21. Signature of Funeral Service Licensee: ▶ Gary S. Kyle
22. Name and Address of Facility: Donaldson Funeral Home, P.A. 313 Talbott Avenue Laurel, Maryland 20707

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Aspiration	minutes
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Neurogenic Dysphagia	months
Due to (or as a consequence of):		
	c. Multi-infarct Dementia	years
Due to (or as a consequence of):		
	d. Cerebrovascular disease	years

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Norton Elson MD
29c. License number: D20362
29d. Date signed *(Month, Day, Year)*: November 6, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Norton Elson 6525 Belcrest Rd #208 Hyattsville MD 20782

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 12 1998
32. Registrar's Signature: ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
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5

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37237

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: EVANGELINE H. FREDRIC

2. Date of Death — Month: November Day: 14 Year: 1998

3. Time of Death: 4:05 pm

4a. Facility Name *(If not institution, give street and number)*: Prince George Hospital Center

4b. City, Town, or Location of Death: Cheverly

4c. County of Death: Prince George

Funeral Director

5. Social Security Number: 213-38-1561

6. Sex: 1☐ M 2☒ F XX

7. Age *(In yrs. last birthday)*: 69 Yrs.

If Under 1 Year — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Date of Birth *(Month, Day, Year)*: Feb. 21, 1929

9. Birthplace *(State or Foreign Country)*: Tn.

Usual Residence of Decedent

10a. State: Md.

10b. County: Prince George

10c. City, Town or Location: Upper Marlboro

10d. Inside City Limits: 1☒ Yes X 2☐ No

10e. Street and Number: 10243 Prince Place

10f. Zip Code: 20774

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced XX

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No XX If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No XX Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*

Elementary/Secondary (0-12):

College (1-4or 5+): 4 years

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Home Ec. Teacher

16b. Kind of Business/Industry: Education

17. Father's Name *(First, Middle, Last)*: George C. Holladay, Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Essie Maude Lamb

19a. Informant's Name/Relationship *(Type, Print)*: Harold Holladay / brother

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 410 McCall Street South Fulton, Tn. 38257

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☒ Removal from State XX 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*

Date:

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee: ▶ Gary S. Kyle

22. Name and Address of Facility: Donaldson Funeral Home, P.A. 313 Talbott Avenue Laurel, Md. 20707

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Exsanguination — minutes

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Massive bleeding via trach tube

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Multisystem organ dysfunction Syndrome
Severe Thrombocytopenia Pancreatitis
Pneumonia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*

Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] MD

29c. License number: D43662

29d. Date signed *(Month, Day, Year)*: 11/16/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William Boyce - P.G. Hosp - 3001 Hospital Drive, Cheverly MD 20785

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 19 1998

32. Registrar's Signature: ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

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To Be Completed by Funeral Director

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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

(2)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37238

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*	2. Date of Death Month / Day / Year	3. Time of Death
JAMES M. FOX	NOV. 13, 1998	3:00PM

4a. Facility Name *(If not institution, give street and number)*	4b. City, Town, or Location of Death	4c. County of Death
636 CHESTER RIVER BEACH ROAD	GRASONVILLE	QUEENANNE'S

Funeral Director

5. Social Security Number	6. Sex	7. Age *(In yrs. last birthday)*	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth *(Month, Day, Year)*	9. Birthplace *(State or Foreign Country)*
222-22-2354	1☐M 2☐F X	61 Yrs.			Nov.16,1936	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	Queen Anne's	Grasonville	1☐Yes 2☐No XX

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
636 Chester River Beach Rd.	21638	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☐Widowed 4☐Divorced XX	1☒Yes 2☐No XX If Yes, Give Year or Dates: 1962-65	1☐Yes 2☐No XX *Specify:*	*Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*		16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Master Electrician	Houchins Elec. Co.

17. Father's Name *(First, Middle, Last)*	18. Mother's Name *(First, Middle, Maiden Surname)*
George Albert Fox	Pearl E. Sterner

19a. Informant's Name/Relationship *(Type, Print)*	19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*
John C. Fox, Brother	743 8thAve. Wilmington, Del. 19808

20a. Method of Disposition	20b. Place of Disposition *(Name of cemetery, crematory or other place)*	Date	20c. Location - City or Town, State
1☒Burial XX 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*	Woodlawn Memorial	Nov. 17,1998	Easton, Md.

21. Signature of Funeral Service Licensee: Amy Jo Michienzi

22. Name and Address of Facility: Fellows,Helfenbein & Newnam Funeral HOme 106 Shamrock Rd., Chester, Md. 21619

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Esophageal Carcinoma	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐Yes 2☐No 3☒Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death *(Check only one)*	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☒Residence 6☐Other *(Specify)*

27. Manner of Death	28a. Date of Injury *(Month, Day Year)*	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*	28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed *(Month, Day, Year)*
David Smith	D39887	11/15/98.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAVID H. SMITH M.D. 509 IDLEWILD AVE. EASTON, MD. 21601

State Registrar

31. Date filed *(Month, Day, Year)*	32. Registrar's Signature
NOV 16 1998	Penny G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37239

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day	Year	3. Time of Death
BRUCE	GUSTINE	NOVEMBER	13	1998	6:25 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
POTOMAC VALLEY NURSING HOME	POTOMAC	MONTGOMERY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	Days	If Under 24 Hrs. Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
407-58-4711	1☒ M 2☐ F	57 Yrs.					AUGUST 7, 1941	MICHIGAN

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	MONTGOMERY	ROCKVILLE	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1235 POTOMAC VALLEY RD	20850	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.)	14. Race - Americen Indian, Black, White, etc.
1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elamentary/Secondary (0-12)	College (1-4or 5+)		
	2	TELLER	BANKING

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
A. NEIL GUSTINE	PAULINE MCCORMICK

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
NOREEN CARRIGAN SISTER	2127 WALLINGFORD RD, ANN ARBOR, MI 48104

20a. Method of Disposition	20b. Place of Disposition (Name of cemetary, cramatory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify)	WASHTENONG MEMORIAL	11/17/98	ANN ARBOR, MI

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility
DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.
1170 ROCKVILLE PIKE - ROCKVILLE, MARYLAND 20852

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onsat and Death
Immediate Cause (Final disease or condition resulting in death)	a. METASTIC ADENO CARCINOMA	6 WEEKS
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate causa. Entar Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequance of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings aveilable prior to completion of cause of death?
1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown	1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Wes casa raferred to medical examinar?	26. Place of Daath (Chack only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☒ Nursing Home 5☐ Rasidence 6☐ Other (Specify)

27. Mannar of Death	28a. Date of Injury (Month, Day Year)	28b. Tima of Injury	28c. Injury at Work?	28d. Dascribe how injury occurred
1☒ Natural 2☐ Accidant 3☐ Suicide 4☐ Homicida 5☐ Panding investigation 6☐ Could not be datarmined		M	1☐ Yas 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Spacify)			28f. Location (Street and Number or Rural Routa Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Phyaician:** To tha best of my knowledge, death occurrad at tha tima, data and place, and due to tha causa(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the tima, data and place, and due to the ceusa(s) and manner stated.

29b. Signature end title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ R. Shakir	D27830	11-13-98

30. Name and address of person who complatad cause of daath (Item 23a) (Type, Print)
RAMLETH SHAKIR, 9019 SHADY GROVE RD, GAITHERSBURG, MD 20877

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 17 1998	[signature]

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37240

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Louise Eileen Gushen

2. Date of Death Month Day Year: NOVEMBER 17, 1998

3. Time of Death: 1:39 PM

4a. Facility Name *(If not institution, give street and number)*: MALCOLM GROW MEDICAL CENTER

4b. City, Town, or Location of Death: CAMP SPRINGS

4c. County of Death: PRINCE GEORGE'S

Funeral Director

5. Social Security Number: 018-20-6996

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 70 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: June 21, 1928

9. Birthplace *(State or Foreign Country)*: Massachusetts

Usual Residence of Decedent

10a. State: MD

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 904 Kerwin Road

10f. Zip Code: 20901

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Francis John Cadagan

18. Mother's Name *(First, Middle, Maiden Surname)*: Hazel Evelyn Abbott

19a. Informant's Name/Relationship *(Type, Print)*: Sandra A. Grozbean (daughter)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8109 Plum Creek Drive, Gaithersburg, MD 20882

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Arlington National Cemetery

Date: 12/1/98

20c. Location - City or Town, State: Arlington, Virginia

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. SEPSIS — 24 HOURS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. ____ Due to (or as a consequence of):

c. ____ Due to (or as a consequence of):

d. ____

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: ISCHEMIC DILATED CARDIOMYOPATHY

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Laura A. Donegan MD

29c. License number: MD-059649-L

29d. Date signed *(Month, Day, Year)*: NOVEMBER 18, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): LAURA A. DONEGAN, CAPT, USAF, MC — 89 MDG/1050 W PERIMETER RD SUITE C1-7 ANDREWS AIR FORCE BASE, MD 20762-6600

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 19 1998

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

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Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

NAME: LOUISE EILEEN GUSHEN

15

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98-37241

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Elaine E. Godsey
2. Dete of Deeth — Month: November; Dey: 13; Yeer: 1998
3. Time of Deeth: 4:33 AM
4a. Fecility Neme (If not institution, give street end number): Doctors Community Hospital
4b. City, Town, or Location of Death: Lanham
4c. County of Deeth: Prince George

Funeral Director

5. Social Security Number: 504-10-1620
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 78 Yrs. — If Under 1 Year: Months / Deys; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Yeer): Dec.7,1919
9. Birthpiece (State or Foreign Country): South Dakota

Usual Residenca of Decedent

10a. State: Maryland
10b. County: Prince George
10c. City, Town or Location: Lanham
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 9207 Greenwood Lane
10f. Zip Code: 20706
10g. Citizen of Whet Country?: U.S.A.

11. Maritel Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Fether's Name (First, Middle, Last): Otto W. Enger
18. Mother's Neme (First, Middle, Maiden Surname): Ella Thompson

19a. Informant's Name/Reletionship (Type, Print): Keith F. Godsey (husband)
19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 9207 Greenwood Lane Lanham, Maryland 20706

20a. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Metropolitan Crematory
Dete: 11/13/98
20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: ▶ James H Stein
22. Neme end Address of Feciliity: Francis J. Collins Funeral Home, Inc. 500 University Blvd.,W.,Silver Spring,MD 20901

Physician /Medical Examiner

23a. Pert I. Enter the disease, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heert failure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Deeth

Immediate Ceuse (Finel disease or condition resulting in deeth)
e. Sepsis — 2 weeks
Due to (or es e consequence of):
b. Pneumonia — 2 weeks

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in deeth) Lest
Due to (or as e consequence of):
c.
Due to (or as e consequence of):
d.

Pert II. **Other elgnificant conditions** contributing to death but not resulting in the underlying cause given in Pert I.
Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☑ No
24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☑ No

26. Piece of Deeth (Check only one): Hospital: 1☑ Inpetient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28e. Date of Injury (Month, Dey Year)
28b. Time of Injury
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, offica building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Phyeicien**: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner**: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end menner stated.

29b. Signeture end titie of certifier: ▶ MD
29c. License number: D20-079
29d. Date signed (Month, Day, Yeer): 11/13/98

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print): Don H. Yoklavich, MD 7401 Executive Pkwy, #502 Rockville, MD 20706

State Registrar

31. Dete filed (Month, Day, Yeer): NOV 16 1998
32. Registrer's Signeture: G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Elaine Helen Enger Godsey

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37242

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Frances Marie Garlock

2. Dete of Deeth — Month: November Day: 18, Yeer: 1998

3. Time of Death: 1:05AM

4e. Feciity Neme *(If not Institution, giva street end number)*: Wilson Health Care Center

4b. City, Town, or Location of Deeth: Gaithersburg

4c. County of Deeth: Montgomery

Funeral Director

5. Social Security Number: 578-26-3327

6. Sax: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 100 Yrs.

If Under 1 Yaar — Months: Days:

If Undar 24 Hrs. — Hours: Min.:

8. Dete of Birth *(Month, Dey, Yeer)*: November 21, 1897

9. Birthpiece *(Steta or Foreign Country)*: Iowa

Usuel Residence of Dacedent

10e. Stete: Maryland

10b. County: Montgomery

10c. City, Town or Location: Gaithersburg

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 403 Russell Avenue, #201

10f. Zip Code: 20877

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yas, Giva Yaar or Datas:

13. Was Decedent of Hispenic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yas 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highast grada completed)*: Elementary/Secondary (0-12): ; College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Giva kind of work done during most of working life. DO NOT use retired)*: Interior Decorator

16b. Kind of Business/Industry: Design

17. Father's Neme *(First, Middle, Last)*: Lucius Cassius Adams

18. Mother's Neme *(First, Middle, Maiden Surneme)*: Jenny Whitman

19e. Inlorment's Neme/Reletionship *(Type, Print)*: Frederick L. Garlock / grandson

19b. Meiling Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 111 Scott Avenue, Glen Burnie, Maryland 21060

20e. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removal from Stete 4☐ Donetion 5☐ Othar *(Specify)*

20b. Plece of Disposition *(Nema of cemetery, cremetory or othar place)*: Montgomery Crematorium, Inc. Date: November 20, 1998

20c. Location - City or Town, Stata: Bethesda, Maryland

21. Signature of Funerel Service Licensee: ▶ Barbara Jo McMullen Lawrence M00831

22. Neme end Addrass of Facility: Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the diaaase, or complicetions that caused the deeth. Do not antar tha mode of dying, such es cardiac or respiretory errest, shock, or haart failure. List only one cause on eech line.

Approximete Intervel Between Onsat end Death

Immediata Ceuse (Finel diseese or condition resulting in death): e. Dehydration — 2 days

Due to (or es e consequence of):

Sequentiellly list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in deeth) Lest:

b. Anorexia

Due to (or es e consequenca ol):

c.

Due to (or es e consequenca ol):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying cause given in Part I.

Hypertension, B-12 defectency anemia, cataracts, Gastroesophageal reflux, Diverticulosis

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy tindings availabla prior to completion of cause of deeth? 1☐ Yas 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Plece of Deeth *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Othar *(Specify)*

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Plece of Injury - At home, Ierm, street, factory, office building, etc. *(Specify)*

28l. Location *(Street end Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) end menner es steted. 2☐ **Medical Examiner:** On tha basis of exeminetion end/or invastigetion, in my opinion, death occurred et the time, dete and place, end due to the ceuse(s) end menner steted.

29b. Signatura and title of certiliar: ▶ Priscilla Callahan Lyons

29c. License number: D 41794

29d. Date signed *(Month, Dey, Yeer)*: November 18, 1998

30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print): Priscilla Callahan-Lyon, MD 911 Russell Ave Gaithersburg, MD 20877

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Division of Vital Records, P.O. Box 68760,

12

State Registrar

31. Date filed *(Month, Day, Yaar)*: NOV 20 1998

32. Registrer's Signature: ▶ G. Sparks

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37243

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Margaret M. Gallagher

2. Data of Death Month Day Yaar: November 17, 1998

3. Tima of Death: 12:47 PM

4a Facility Nama *(If not institution, giva straat and number)*: 2215 Newton Drive

4b. City, Town, or Location of Deeth: Rockville

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-12-0269

6. Sax: 1☐ M 2☒ F

7. Aga *(In yrs. last birthday)*: 87 Yrs.

If Undar 1 Yaar: Months / Deys

If Undar 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Yaar)*: March 13, 1911

9. Birthplace *(Stata or Foreign Country)*: Washington, D.C.

Usual Residance of Decedant

10a. Stete: Maryland

10b. County: Montgomery

10c. City, Town or Location: Rockville

10d. Inside City Limits: 1☒ Yas 2☐ No

10e. Street and Number: 2215 Newton Drive

10f. Zip Code: 20850

10g. Citizan of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedant Evar in U.S. Armad Forcas? 1☐ Yes 2☒ No If Yas, Giva Year or Datas:

13. Was Decedant of Hispenic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No *Specify:*

14. Race - Amarican Indian, Black, Whita, atc. *Specify:* White

15. Dacedant's Education *(Spacify only highest grada compliated)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): –

16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT use ratired)*: Secretary

16b. Kind of Businass/Industry: Montgomery County Public Schools

17. Fether's Nema *(First, Middle, Last)*: Thomas M. Nolan

18. Mothar's Name *(First, Middla, Maidan Surnama)*: Mary Margaret Forde

19a. Informant's Name/Ralationship *(Type, Print)*: Patrick M. Gallagher/ Son

19b. Mailing Address *(Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: 2206 Abbotsford Drive, Vienna, Virginia 22181

20a. Mathod of Disposition: 1☒ Burial 2☐ Cremation 3☐ Ramoval from Stata 4☐ Donation 5☐ Other *(Spacify)*

20b. Place of Disposition *(Nama of cematary, cramatory or othar place)*: Cedar Hill Cemetery

Data: November 21, 1998

20c. Location - City or Town, Stata: Suitland, Maryland

21. Signature of Funaral Servica Licansee: M00689

22. Nama and Addrass of Facility: Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805

Physician /Medical Examiner

23a. Part I. Entar tha diseasa, or complications that caused the deeth. Do not antar tha mode of dying, such es cardiac or respiretory arrast, shock or heart failure. List only ona causa on aach line.

Approximata Intarval Betwaen Onset and Death

Immediata Cause (Final disaasa or condition rasulting in daath)

a. Myocardial Infarction — 24 hrs

Dua to (or as a consaquanca of):

Sequentially list conditions, if any, laading to immadiata cause. Entar Undarlying Causa (Disease or injury that initiated avants rasulting in daath) Lest

b. Coronary Artery Disease — 5 years

Dua to (or es e consaquance of):

c. Arteriosclerotic Heart Disease — 10 years

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying cause given in Part I.

Gallbladder disease

Hypertension

Endometriosis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy parformed? 1☐ Yas 2☒ No

24b. Were autopsy findings availeble prior to complation of causa of daath? 1☐ Yas 2☐ No

25. Was casa raferred to medical axaminar? 1☒ Yas 2☐ No

26. Placa of Daath *(Check only ona)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpatiant 3☐ DOA; Other: 4☐ Nursing Home 5☒ Rasidanca 6☐ Other *(Specify)*

27. Mannar of Daath: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Pending invastigation 6☐ Could not be datarmined

28a. Data of Injury *(Month, Day Yaar)*

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28a. Place of Injury - At home, farm, straat, factory, offica building, etc. *(Specify)*

28f. Location *(Straat and Number or Rural Routa Number, City or Town, Stata)*

29a. Cartifiar *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledga, daath occurred at tha tima, data and place, and dua to the cause(s) and mannar as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, daath occurred at the tima, data and placa, and due to the cause(s) and mannar stated.

29b. Signatura and tilla of certifiar: E. P. Libre M.D.

29c. License number: D09470

29d. Date signed *(Month, Day, Year)*: November 18, 1998

30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print): Eugene P. Libre, M.D. 10400 Connecticut Avenue, #606, Kensington, Maryland 20895

State Registrar

31. Data filad *(Month, Day, Year)*: NOV 20 1998

32. Registrar's Signatura: Geneva G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37244

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*	2. Dete of Deeth Month / Day / Year	3. Time of Death
Carolyn D. Giovanos	November 15 1998	2:22am

4e Fecility Neme *(If not institution, give street and number)*	4b. City, Town, or Location of Deeth	4c. County of Deeth
Howard County General Hospital	Columbia	Howard

Funeral Director

5. Socie! Security Number	6. Sex	7. Age *(In yrs. last birthday)*	If Under 1 Year: Months / Deys	If Under 24 Hrs.: Hours / Min.	8. Date of Birth *(Month, Day, Year)*	9. Birthplece *(State or Foreign Country)*
218-03-5095	1☐ M 2☒ F	82 Yrs.			July 30,1916	Maryland

Usuel Residence of Decedent

10e. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Howard	Columbia	1☐ Yes 2☒ No

10e. Street end Number	10f. Zip Code	10g. Citizen of Whet Country?
Harmony Hall 6334 Cedar Lane	21044	United States

11. Maritel Status	12. Was Decedent Ever in U,S. Armed Forces?	13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Yeer or Dates:	1☐ Yes 2☒ No *Specify:*	*Specify:* White

15. Decedent's Eduestion *(Specify only highest grade completed)*		16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*	16b. Kind of Business/Industry
Elementery/Secondary (0-12)	College (1-4or 5+)		
12		Homemaker	Own Home

17. Fether's Name *(First, Middle, Last)*	18. Mother's Name *(First, Middle, Maiden Surneme)*
Harry Rumpf	Birdie Grace Barnes

19e. Informent's Name/Relationship *(Type, Print)*	19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*
Antonia Wolff/Daughter	3917 Hawthorn Road Ellicott City, MD 21042

20e. Method of Disposition	20b. Piece of Disposition *(Name of cemetery, crematory or other place)*	Date	20c. Location - City or Town, Stete
1☒ Buriel 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*	Garrison Forest Vetr. Cem.	11-18-98	Owings Mills, MD

21. Signature of Funerel Service Licensee	22. Neme end Address of Feeility
▶ Sharon A Collins-Wittyke	Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one cause on eech line.

		Approximate Intervel Between Onset end Deeth
Immediate Ceuse (Final diseese or condition resulting in deeth)	e. Myocardial Infarction	1 week
	Due to (or es e consequence of):	
Sequentielly list conditions, if eny, leeding to immediete ceuse. Enter Underlying Ceuse (Disease or Injury that Initieted events resulting in death) Lest	b.	
	Due to (or es e consequence of):	
	c.	
	Due to (or es e consequence of):	
	d.	

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ **Yes** 2☐ **No** 3☐ **Probably** 4☒ **Unknown**

24a. Wes en eutopsy performed?	24b. Were eutopsy findings available prior to completion of ceuse of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Wes case referred to medical examiner?	26. Place of Death *(Check only one)*	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Deeth	28a. Date of Injury *(Month, Day Year)*	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Plece of Injury - At home, farm, street, fectory, offica building, etc. *(Specify)*			28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*

1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

2☐ **Medical Examiner:** On the basis of exemlnetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the cause(s) end manner stated.

29b. Signeture end title of certifier	29c. License number	29d. Date signed *(Month, Day, Yeer)*
▶ Pio Poblete MD	D50338	November 15, 1998

30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print)
Pio L Poblete, 11055 Little Patuxent Parkway, Columbia MD 21044

State Registrar

31. Dete filed *(Month, Day, Yeer)*	32. Registrer's Signature
NOV 17 1998	▶ Geneva G. Sparks

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 37245

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Azell L. Gordon

2. Date of Death — Month: November Day: 12 Year: 1998

3. Time of Death: 10:26am

4e. Facility Name *(If not institution, give street and number)*: 4950 Orchard Drive

4b. City, Town, or Location of Death: Ellicott City

4c. County of Death: Howard

Funeral Director

5. Social Security Number: 439-34-6559

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 73 Yrs.

If Under 1 Year — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Date of Birth *(Month, Day, Year)*: Sept 28, 1925

9. Birthplace *(State or Foreign Country)*: Louisiana

Usual Residence of Decedent

10e. State: Maryland

10b. County: Howard

10c. City, Town or Location: Ellicott City

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 4950 Orchard Drive

10f. Zip Code: 21043

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*

Elementary/Secondary (0-12): 11

College (1-4or 5+):

16e. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Cloth Inspector

16b. Kind of Business/Industry: Textile

17. Father's Name *(First, Middle, Last)*: Elbert Jackson

18. Mother's Name *(First, Middle, Maiden Surname)*: Lillian unknown

19e. Informant's Name/Relationship *(Type, Print)*: Robert L. Gordon Jr./Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 34 Duke Power Rd Granite Falls, NC 28630

20e. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Meadowridge Cemetery

Date:

20c. Location - City or Town, State: 11-16-98 Elkridge, Maryland

21. Signature of Funeral Service Licensee: ▶ Shawn a. Collins-Witzke

22. Name and Address of Facility: Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Large cell lymphoma — 6 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*

1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Nicholas Jd Kondakis Asst

29c. License number: D38509

29d. Date signed *(Month, Day, Year)*: November 13, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Nicholas Jd Kondakis 11065 Little Patuxent Pkwy Columbia MD 21044

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 13 1998

32. Registrar's Signature: ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98-37246

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ELLEN C. HAUSER

2. Data of Death: Month Nov, Day 21, Year 98

3. Time of Death: 2110

4a. Facility Name *(If not institution, give street and number)*: 1 MEADOW ST

4b. City, Town, or Location of Death: BERLIN

4c. County of Death: WORCESTER

Funeral Director

5. Social Security Number: 214-12-4000

6. Sex: 1☐ M 2☑ F

7. Age *(In yrs. last birthday)*: 84 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: 12 20 13

9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD

10b. County: WORCESTER

10c. City, Town or Location: BERLIN

10d. Inside City Limits: 1☑ Yes 2☐ No

10e. Street and Number: 1 MEADOW ST

10f. Zip Code: 21811

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☑ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No. If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☑ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOMEMAKER

16b. Kind of Business/Industry: OWN HOME

17. Father's Name *(First, Middle, Last)*: JEROME GOLLERY

18. Mother's Name *(First, Middle, Maiden Surname)*: ALICE PETERS

19a. Informant's Name/Relationship *(Type, Print)*: FRANK T. HAUSER SR.

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 601 DORY RD. #2 OCEAN CITY, MD. 21842

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: LORRAINE PARK

Date: 11-24

20c. Location - City or Town, State: BALTIMORE, MD.

21. Signature of Funeral Service Licensee:

22. Name and Address of Facility: ULLRICH FUNERAL HOME BERLIN, MD. 21811

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Lung Cancer — Approximate Interval: 4 years

Due to (or as a consequence of):
b. ASCVD

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☑ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)* Assisted Living Community

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: 028769

29d. Date signed *(Month, Day, Year)*: 11/23/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): NICHOLAS N. BORDONARO, MD. 1209 OCEAN HIGHWAY FENWICK ISLAND, DE 19944

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 23 1998

32. Registrar's Signature: Jeanne G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

98-6414-510
B.K.S
RONALD HARTLING
ITEMS: ##23 PART I, 27, 28A-F PER MEO G766 12-7-98 WR

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37247

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Ronald E. Hartling	NOV. 4, 1998	1324 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
12 SOUTH CASTLE STREET	BALTIMORE	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
001-54-2786	1[X] M 2[ ] F	36 Yrs.			July 27, 1962	Massachusetts

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland		Baltimore	1[X] Yes 2[ ] No

10e. Street and Number	10f. Zip Code	10g. Citizen of Whet Country?
12 South Castle Street	21231	United States of America

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - Americen Indien, Bleck, White, etc.
1[X] Never Married 2[ ] Married 3[ ] Widowed 4[ ] Divorced	1[ ] Yes 2[X] No If Yes, Give Year or Detes:	1[ ] Yes 2[X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11		Disabled	unknown

17. Fether's Name (First, Middle, Last)	18. Mother's Neme (First, Middle, Maiden Sumeme)
Arnold E. Hartling	Carolyn Morris

19e. Informent's Name/Relationship (Type, Print)	19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code)
Carolyn Hartling	33 Lincoln Street Somersworth, NH 03878

20a. Method of Disposition	20b. Piece of Disposition (Neme of cemetery, cremetory or other piece)	Dete	20c. Location - City or Town, Stete
1[ ] Burial 2[X] Cremation 3[ ] Removel from State 4[ ] Donetion 5[ ] Other (Specify)	Metropolitan Crematory	Nov. 11, 1998	Alexandria, Virginia

21. Signature of Funeral Service Licensee	22. Name and Address of Feciliity
Kuen W. Dove	William Purdy Funeral Home 655 Central Avenue Dover, NH 03820

DNW

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications thet ceused the death. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heart failure. List only one cause on eech line.

		Approximete Intervel Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. COCAINE AND NARCOTIC INTOXICATION	
	Due to (or es e consequence of):	
Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Disease or Injury thet initiated events resulting in deeth) Lest	b. Due to (or es e consequence of):	
	c. Due to (or es a consequence of):	
	d.	

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1[ ] Yes 2[ ] No 3[ ] Probably 4[X] Unknown

24e. Wes en eutopsy performed?	24b. Were eutopsy findings eveilable prior to completion of cause of deeth?
1[X] Yes 2[ ] No	1[X] Yes 2[ ] No

25. Wes cese referred to medical examiner?	26. Piece of Deeth (Check only one)	
[X] Yes 2[ ] No	Hospital: 1[ ] Inpetient 2[ ] ER/Outpetient 3[ ] DOA	Other: 4[ ] Nursing Home [X] Residence 6[ ] Other (Specify)

27. Menner of Deeth	28a. Dete of Injury (Month, Dey Yeer)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1[ ] Netural 2[ ] Accident 3[ ] Suicide 4[ ] Homicide 5[ ] Pending investigation 6[X] Could not be determined	Found: 11-4-98	Found: 1:15 p M	1[ ] Yes 2[X] No	UNKNOWN

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
FOUND AT RESIDENCE	12 SOUTH CASTLE ST. BALTIMORE, MARYLAND

29a. Certifier (Check only one) 1[ ] **Certifying Phyeician:** To the best of my knowledge, death occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted. 2[X] **Medical Examiner:** On the besis of exeminetion end/or investigation, in my opinion, death occurred et the time, dete end place, end due to the ceuse(s) and manner stated.

29b. Signature end title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Theodore McKin MD	O.C.M.E	NOV. 5, 1998

30. Neme and address of person who completed ceuse of deeth (Item 23e) (Type, Print)
THEODORE McKIN 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signeture
NOV 16 1998	Donna G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37248

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Dete of Deeth Month / Dey / Yeer	3. Time of Death
Carmelita Hurley		November 17, 1998	6:25A.M.
4e Fecility Neme (If not institution, give street end number)	4b. City, Town, or Location of Deeth	4c. County of Death	
Manor Care Potomac	Potomac	Montgomery	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Deys	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Dey, Yeer)	9. Birthplece (Stete or Foreign Country)
055-30-2524	1☐ M 2☒ F	86 Yrs.			July 16, 1912	New Jersey

Usuel Residence of Decedent

10e. Stete	10b. County	10c. City, Town or Location	10d. Inside City Limits
NJ	Essex	Short Hills	1☐ Yes 2☒ No

10e. Street end Number	10f. Zip Code	10g. Citizen of Whet Country?
#1 Alan Drive	07078	United States

11. Maritel Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - Americen Indien, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Yeer or Detes:	1☐ Yes 2☒ No *Specify:*	*Specify:* White

15. Decedent's Eduction (Specify only highest grede completed)		16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondary (0-12)	College (1-4or 5+)		
	4	Housewife	Own Home

17. Fether's Name (First, Middle, Last)	18. Mother's Neme (First, Middle, Maiden Surname)
Daniel Leo McCormick	Sarah Convery

19a. Informent's Name/Relationship (Type, Print)	19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code)
Carmelita Treacy (Daughter)	9913 Kentsdale Drive Potomac, Md. 20854

20a. Method of Disposition	20b. Piece of Disposition (Neme of cemetery, crematory or other piece)	Dete	20c. Location - City or Town, Stete
1☒ Burial 2☐ Cremetion 3☐ Removal from Stete 4☐ Donation 5☐ Other (Specify)	Gate of Heaven Cemetery	Nov. 20, 1998	E. Hanover, NJ

21. Signature of Funeral Service Licensee	22. Name end Address of Feciility
▶ Curtis E. Doyle	DeVol Funeral Home 10 East Deer Park Dr. Gaithersburg, Md. 20877

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such es cerdiec or respiretory errest, shock, or heart failure. List only one ceuse on eech line.

		Approximete Interval Between Onset end Deeth
Immediate Cause (Final diseese or condition resulting in death)	e. Myocardial Infarction	Hours
	Due to (or es e consequence of):	
Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest	b.	
	Due to (or es e consequence of):	
	c.	
	Due to (or es e consequence of):	
	d.	

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying ceuse given in Pert I.

Dementia

23b. Did tobacco use contribute to the cauee of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Wes en eutopsy performed?	24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Wes cese referred to medical examiner?	26. Place of Deeth (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA	Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28e. Dete of Injury (Month, Dey Yeer)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end place, end due to the ceuse(s) end menner es steted.
2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and place, end due to the ceuse(s) end menner steted.

29b. Signature end title of certifier	29c. License number	29d. Date signed (Month, Dey, Yeer)
▶ Michael J Grady	D0038781	November 17, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Michael J. Grady, M.D. 4910 Mass. Ave. N.W. #312 Washington, D.C. 20016-4300

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year) NOV 19 1998

32. Registrer's Signeture Jenna G. Sparks

DHMH 16 Rev 6/95

98 37219

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Audrey H. Hunt			2. DATE OF DEATH (Month, Day, Year): November 13 1998	3. TIME OF DEATH: 10 55 PM
4. SOCIAL SECURITY NUMBER: 577-16-0225	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 79 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.)	7. DATE OF BIRTH (Month, Day, Year): Sept. 16, 1919	8. BIRTHPLACE (State or Foreign Country): Washington, DC
9a. FACILITY NAME (If not institution, give street and number): Montgomery General Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Olney		9c. COUNTY OF DEATH: Montgomery
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Bethesda		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 5908 Conway Road		10f. ZIP CODE: 20814		10g. CITIZEN OF WHAT COUNTRY?: United States
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Grants Technical Assistant	16b. KIND OF BUSINESS/INDUSTRY: National Institutes of Health		
17. FATHER'S NAME (First, Middle, Last): James Spencer Readmon		18. MOTHER'S NAME (First, Middle, Maiden Surname): Anna Kathleen McVeary		
19a. INFORMANT'S NAME (Type/Print): George W. Hunt, III/Son		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 428 Bostwick Lane, Gaithersburg, Maryland 20878		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Gate of Heaven Cemetery DATE: Nov. 17, 1998	20c. LOCATION — City or Town, State: Silver Spring, MD		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: David E. Perry M00803	22. NAME AND ADDRESS OF FACILITY: Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. acute myocardial infarction	1 hour
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d. DUE TO (OR AS A CONSEQUENCE OF):	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I: dementia

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
John R. Melnich MD	D19291	November 14, 1998

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): John R. MELNICH 911 Russell Ave Gaithersburg Md 20879

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
NOV 16 1998	Geneva B. Sparks

DHMH-18 Rev 1/89

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37250

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Helen Yao Hsiao
2. Dete of Deeth: Month November Day 15 Yeer 1998
3. Time of Death: 12:20 PM
4e Feclity Neme *(If not institution, give street end number)*: 1811 Metzerott Road, #801
4b. City, Town, or Location of Deeth: Adelphi
4c. County of Deeth: Prince George's

Funeral Director

5. Social Security Number: 578-48-2380
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. lest birthday)*: 81 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Dey, Yeer)*: Oct. 6, 1917
9. Birthplece *(State or Foreign Country)*: China

Usuel Residence of Decedent

10e. Stete: Maryland
10b. County: Prince George's
10c. City, Town or Location: Adelphi
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 1811 Metzerott Road, #801
10f. Zip Code: 20783
10g. Citizen of Whet Country?: United States
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indien, Black, White, etc. *Specify:* Chinese
15. Decedent's Education *(Specify only highest grede completed)*: Elementery/Secondery (0-12) / College (1-4or 5+): 4
16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Chemist
16b. Kind of Business/Industry: Gillette Research
17. Fether's Neme *(First, Middle, Last)*: Shih-chien Yao
18. Mother's Name *(First, Middle, Maiden Sumeme)*: Yueh-chiao Wu
19e. Informent's Neme/Relationship *(Type, Print)*: Dorothy S. Hsiao (daughter)
19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 4702 Fort Sumner Drive, Bethesda, MD 20816
20a. Method of Disposition: 1☒ Buriel 2☐ Cremation 3☐ Removel from Stete 4☐ Donetion 5☐ Other *(Specify)*
20b. Placa of Disposition *(Neme of cemetery, cremetory or other piece)*: Rock Creek Cemetery
Date: 11-21-98
20c. Location - City or Town, State: Washington, DC
21. Signature of Funeral Service Licensee: Richard L. Rapp
22. Name and Address of Feciility: Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DNW

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Deeth

Immediate Ceuse (Final diseese or condition resulting in death)
e. Liver Failure
Due to (or es e consequenca of):
Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Lest
b. Cirrhosis
Due to (or es e consequenca of):
c. Cystic Liver Disease & Hepatitis B
Due to (or as e consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.: Cerebrovascular Hemorrhage

23b. Did tobacco uee contribute to the cauea of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Piece of Deeth *(Check only one)*: Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Date of Injury *(Month, Dey Yeer)*
28b. Time of Injury
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, ferm, street, factory, offica building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred et the time, date end piece, and due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner**: On the basis of exemination end/or investigetion, In my opinion, deeth occurred et the time, date end place, end due to the cause(s) end menner steted.

29b. Signeture and title of certifier: Sidney J. Malawer MD
29c. License number: D 07408
29d. Date signed *(Month, Dey, Yeer)*: November 16, 1998

30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print): Sidney J. Malawer, M. D., 10215 Fernwood Road, #401, Bethesda, MD 20817-1184

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for usa as the burial-transit

20

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 18 1998
32. Registrer's Signature: Penne B. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 37251

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): VIRGINIA M. HORN
2. Date of Death (Month, Day, Year): November 15 1998
3. Time of Death: 1500
4e. Facility Name (If not institution, give street and number): Shady Grove Hospital
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 583-40-4598
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 76 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): August 26, 1922
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Md.
10b. County: Montgomery
10c. City, Town or Location: Gaithersburg
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 20 West Deer Park Rd. #103
10f. Zip Code: 20877
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Charles Schwalm
18. Mother's Name (First, Middle, Maiden Surname): Hazel Pendergast

19a. Informant's Name/Relationship (Type, Print): Bernard Horn (Son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 402 First Street Rockville, Md. 20851

20e. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory | Date: Nov. 19, 1998
20c. Location - City or Town, State: Alexandria, Va.

21. Signature of Funeral Service Licensee: ▶ Curtis E. Day
22. Name and Address of Facility: DeVol Funeral Home 10 East Deer Park Dr. Gaithersburg, Md. 20877

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Pneumonia	
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Chronic Obstructive Pulmonary Disease	
Due to (or as a consequence of):		
	c. Renal Insufficiency	
Due to (or as a consequence of):		
	d. Hypothyroidism	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Joseph A Ball MD
29c. License number: 53317
29d. Date signed (Month, Day, Year): November 16 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph A. Ball M.D. 16220 Frederick Road Suite 213 Gaithersburg MD 20877

State Registrar

31. Date filed (Month, Day, Year): NOV 19 1998
32. Registrar's Signature: ▶ G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37252

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: William Bill Holliday
2. Date of Death Month Dey Year: November 13, 1998
3. Time of Deeth: 7:30 AM
4a. Facility Name *(If not institution, give street end number)*: 6412 85th Avenue
4b. City, Town, or Location of Deeth: New Carrollton
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 416-01-0479
6. Sex: 1☒M 2☐F
7. Age *(In yrs. last birthdey)*: 87 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Dey, Yeer)*: March 9, 1911
9. Birthplece *(State or Foreign Country)*: Winchester, TN

Usual Residence of Decedent

10a. State: MD
10b. County: Prince George's
10c. City, Town or Location: New Carrollton
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 6412 85th Avenue
10f. Zip Code: 20784
10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*
14. Race - American Indien, Black, White, etc. *Specify:* White

15. Decedent's Eduestion *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 6 / College (1-4or 5+):
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Fixer
16b. Kind of Business/Industry: Textiles

17. Father's Name *(First, Middle, Last)*: Will Holliday
18. Mother's Name *(First, Middle, Maiden Sumame)*: Lula Finchem

19a. Informant's Name/Relationship *(Type, Print)*: Ila Myers - Daughter
19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, State, Zip Code)*: 6412 85th Avenue, New Carrollton, MD 20784

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, cremetory or other piece)*: Maple Hill Cemetery
Date: Nov. 17, 1998
20c. Location - City or Town, State: Huntsville, Alabama

21. Signeture of Funeral Service Licensee: Karen W. Dove
22. Neme end Address of Fecility: Laughlin Funeral Home 35805
2320 Bob Wallace Avenue, South Huntsville, AL

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Intervel Between Onset end Death

Immediate Cause (Final disease or condition resulting in death): e. Cerebrovascular Accident (Stroke)

Due to (or es a consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Hypertension

Due to (or as a consequence of):

c. Cerebrovascular Disease

Due to (or as a consequence of):

d.

Part II. **Other significent conditions** contributing to death but not resulting in the underlying ceuse given in Part I.: Decubitus Ulcers

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings evaileble prior to completion of ceuse of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Piece of Death *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpetient 3☐DOA Other: 4☐Nursing Home 5☒Residence 6☐Other *(Specify)*

27. Manner of Deeth: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician**: To the best of my knowledge, death occurred at the time, date and piece, end due to the cause(s) and manner as steted. 2☐**Medical Examiner**: On the basis of examination and/or investigation, In my opinion, death occurred et the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signeture end title of certifier:
29c. License number: D48200
29d. Date signed *(Month, Dey, Year)*: 11/17/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Alec Anders, M.D. 8824 Cunningham Drive #B, Berwyn Heights, MD

State Registrar

31. Dete filed *(Month, Day, Year)*: NOV 19 1998
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours eftar death with the Marylend Department of Health and Mantal Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requiras thet the death certificata be executed within 24 hours aftar death.
To the Funeral Director: Aftar this certificate has been signed by the attending physician end completely filled in by the funeral director, paga 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37253

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ralph Hollers
2. Date of Death (Month, Day, Year): November 11 1998
3. Time of Death: 1102 am
4a. Facility Name (If not institution, give street and number): The Johns Hopkins Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 234-07-5564
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 4, 1916
9. Birthplace (State or Foreign Country): Ohio

Usual Residence of Decedent

10a. State: N/A
10b. County: N/A
10c. City, Town or Location: Washington, D.C.
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 4201 Cathedral Avenue, N.W.
10f. Zip Code: 20016
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Detes:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 2+ College (1-4or 5+)
16a. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired): Businessman
16b. Kind of Business/Industry: Entrepreneur

17. Father's Name (First, Middle, Last): John Hollers
18. Mother's Name (First, Middle, Maiden Surname): Catherine Goodall

19a. Informant's Name/Relationship (Type, Print): Ann-Kathryn Messina Grand daughter
19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Code): 4201 Cathedral Avenue, NW, Washington, DC 20016

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremetion 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other place): Baltimore/Washington Crematory
Date: 11/14
20c. Location - City or Town, Stete: Laurel, Maryland

21. Signature of Funerel Service Licensee ▶
22. Name and Address of Facility: Joseph Gawler's Sons, Inc. 5130 Wisconsin Avenue NW, Washington, D.C. 20016

DMW

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failura. List only ona causa on each lina.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death)
e. Multi system organ failure — 7 days
Due to (or es a consequence of):
b. Intrabdominal Sepsis — 11 days
Sequentially tist conditions, if any, leading to immedieta cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Dua to (or es e consequence of):
c.
Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Mal nutrition
Mitral Valve disease

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Wes en eutopsy performed? 1 ☒ Yes 2 ☐ No
24b. Were autopsy findings eveilable prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case refarred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Placa of Daeth (Check only one): Hospitel: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Rasidance 6 ☐ Othar (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Data of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end manner as stated. 2 ☐ **Medical Examiner:** On tha basis of examinetion and/or investigation, in my opinion, death occurred et the time, data and place, and dua to tha cause(s) end menner stated.
29b. Signature and title of certifier ▶ MD
29c. License number: D50537
29d. Date signed (Month, Day, Year): November 11 1998
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): HERBERT J. ZEH III MD

State Registrar

31. Date filed (Month, Day, Year): NOV 16 1998
32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

12

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37254

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Anna Margaret Himmer
2. Date of Death (Month, Day, Year): Nov. 14, 1998
3. Time of Death: 6:30 PM
4e. Facility Name (If not institution, give street and number): Foxchase Nursing Home
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 020-22-9232
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 10, 1913
9. Birthplace (State or Foreign Country): Massachusetts

Usual Residence of Decedent

10e. State: none
10b. County: none
10c. City, Town or Location: Washington, D.C.
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street end Number: 3636 16th St.,N.W.
10f. Zip Code: 20010
10g. Citizen of Whet Country?: U.S.A.

11. Meritel Stetus: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - Americen Indien, Bleck, White, etc. Specify: white

15. Decedent's Educetion (Specify only highest grade completed): Elementery/Secondery (0-12): 12 | College (1-4or 5+):
18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary
16b. Kind of Business/Industry: U.S. Government

17. Fether's Name (First, Middle, Last): Andrew Himmer
18. Mother's Neme (First, Middle, Maiden Surname): Margaret Max

19a. Interment's Name/Relationship (Type, Print): Alan W. Himmer/nephew
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): Box 3157, Belleview, Fla. 34421

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Metropolitan Crematory
Dete: Nov. 18 1998
20c. Location - City or Town, Stete: Alexandria, Virginia

21. Signature of Funeral Service Licensee: [signature]
22. Neme end Address of Fecility: DeVol Funeral Home 2222 Wisconsin Ave.,N.W.,Wash.,DC 20007

Physician /Medical Examiner

23a. Part I. Enter the disease, or complicetions that caused the deeth. Do not enter the mode of dying, such es cerdiac or respiretory arrest, shock, or heart failure. List only one ceuse on eech line. | Approximate Interval Between Onset end Deeth

Immediate Cause (Final disease or condition resulting in deeth)
e. Sudden death — instant

Due to (or es a consequence of):
b. Ventricular arrhythmia — years

Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest
Due to (or es e consequence of):
c.
Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.
Dialated cardiomyopathy
Congestive heart failure

23b. Did tobacco uee contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings aveilable prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Plece of Deeth (Check only one): Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) end menner es steted.
2☐ **Medical Examiner:** On the basis of examination end/or investigetion, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D28656
29d. Date signed (Month, Dey, Year): November 16, 1998

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print): Ravi Passi 8609 2nd Avenue #404B Silver Spring, Maryland 20910

State Registrar

31. Dete filed (Month, Day, Yeer): NOV 19 1998
32. Registrer's Signature: [signature]

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit order.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37255

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lynette May High

2. Date of Death: Month Nov Day 12 Year 98

3. Time of Death: 10:00 pm

4a. Facility Name (If not institution, give street and number): Charlestown Care Center

4b. City, Town, or Location of Death: Catonsville

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 577-03-4652

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 94 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): August 5, 1904

9. Birthplace (State or Foreign Country): Washington, D.C.

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Catonsville

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 701 Maidenchoice Lane

10f. Zip Code: 21228

10g. Citizen of What Country? U.S.A.

11. Maritel Stetus: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - Americen Indien, Black, Whlte, etc. Specify: white

15. Decedent's Educetion (Specify only highest grede completed): Elementary/Secondary (0-12) 12; College (1-4or 5+)

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Supervisor

16b. Kind of Business/Industry: Acacia Life Insurance Company

17. Father's Neme (First, Middle, Last): Henry High

18. Mother's Name (First, Middle, Maiden Surneme): Carrie Russell

19a. Informent's Name/Relationship (Type, Print): Harry J. High Nephew

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 13903 Sunnybrook Road, Pheonix, MD 21131

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Glenwood Cemetery

Dete: 11/18

20c. Location - City or Town, State: Washington, D.C.

21. Signature of Funeral Service Licensee: Deah M. Peters

22. Name and Address of Facility: Joseph Gawler's Sons, Inc. 5130 Wisconsin Avenue N.W., Washington, D.C. 20016

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Pert1. Ente the disease, or complicetions that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or Heert feilure. List only one cause on eech line.

Approximate Interval Between Onset end Death

Immediete Ceuse (Final diseese or condition resulting in deeth)

e. End Stage Dementia — years

Due to (or es e consequence of):

Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Lest

b. Due to (or es e consequence of):

c. Due to (or es e consequence of):

d.

Pert II. **Other significent conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☑ No

24b. Were eutopsy findings evailable prior to completion of ceuse of deeth? 1☐ Yes 2☑ No

25. Wes cese referred to medical exeminer? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Phyeicien:** To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of exeminetion end/or investigetion, in my opinion, death occurred et the time, dete end place, end due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier: Andres Salazar MD

29c. License number: D 51051

29d. Date signed (Month, Dey, Year): November 13, 1998

30. Neme end eddress of person who completed ceuse of deeth (Item 23a) (Type, Print): Andres Salazar 711 Maiden choice Lane, Catonsville, MD, 21228

State Registrar

31. Dete filed (Month, Day, Year): NOV 16 1998

32. Registrer's Signeture: Jenna B. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificete be executed within 24 hours after death.

To the Funeral Director: After this certificete has been signed by the attending physician and completely filled in by the funerel director, page 2 should be detached for use es the burial-transit

Name: Lynette high

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37256

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Dey	Year	3. Time of Death
Anne	W.	Herman	November	19	1998	8:40AM

4e Facility Name (If not institution, give street end number)	4b. City, Town, or Location of Death	4c. County of Death
Hebrew Home of Greater Washington	Rockville	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Deys	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Dey, Year)	9. Birthplece (State or Foreign Country)
579 40 0184	1☐ M XX F	86 Yrs.					March 28 1912	Maryland

Usual Residence of Decedent

10e. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Prince Georges	Bowie	XX Yes 2☐ No

10e. Street end Number	10f. Zip Code	10g. Citizen of Whet Country?
3201 Superior Lane	20715	USA

11. Marital Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indien, Black, White, etc.
1☐ Never Merried 2☐ Married 3XX Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Yeer or Detes:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	2	Secretary	Temple Israel

17. Fether's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Meiden Surneme)
David Weisberg	Tillie Himmelfarb

19a. Informant's Neme/Reletionship (Type, Print)	19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)
Theodore David Herman/son	3201 Superior Lane Bowie, Maryland 20715

20a. Method of Disposition	20b. Place of Disposition (Neme of cemetery, crematory or other piece)	Dete	20c. Location - City or Town, Stete
X Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)	Mt Lebanon Cemetery	11/20/98	Adelphi, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name end Address of Feciility: Danzansky Goldberg Memorial Chapel 1170 Rockville Pike Rockville, Maryland 20852

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset end Death
Immediate Cause (Final disease or condition resulting in death) e.	Myocardial infarction	Immediate
Due to (or es e consequence of): b.	Coronary artery disease	Years
Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Ceuse (Disease or Injury that Initieted events resulting in deeth) Lest — Due to (or as e consequence of): c.	Diabetes mellitus type II	Years
Due to (or as a consequence of): d.		

Part II. **Other significent conditione** contributing to deeth but not resulting in the underlying cause given in Part I.

Non-Hodgkins lymphoma

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2X No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed?	24b. Were eutopsy findings eveilable prior to completion of cause of deeth?
1☐ Yes 2X No	1☐ Yes 2☐ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Wes case referred to medical examiner?	26. Piece of Deeth (Check only one)	
1☐ Yes 2X No	Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA	Other: 4X Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Deeth	28e. Dete of Injury (Month, Dey Year)	28b. Time of Injury M	28c. Injury et Work?	28d. Describe how injury occurred
1X Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined			1☐ Yes 2☐ No	
	28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)			28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1X **Certifying Physician:** To the best of my knowledge, death occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted.
2☐ **Medical Examiner:** On the besis of examination end/or investigetion, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner steted.

29b. Signature end title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)
[signature] MD	D23958	11/19/98

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)
Burt I. Feldman MD 6105 Montrose Rd., Rockville MD 20852

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signeture
NOV 20 1998	[signature] D. Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: Tha law requiras that the daath cartificata be axecutad within 24 hours after death.
To the Funeral Director: Aftar this cartificata has been signed by tha attanding physician and completely filled in by tha funaral director, paga 2 should be datached for usa as tha burial-transit

To Be Completed by Funeral Director

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37257

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mary Heckler

2. Date of Death Month Dey Year: Nov 11 1998

3. Time of Death: 02:10am

4a. Facility Name *(If not institution, give street and number)*: Holy Cross Hospital

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 427-05-8743

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 83 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 18, 1915

9. Birthplace *(State or Foreign Country)*: Maben, MS

Usual Residence of Decedent

10a. State: MD

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 901 Arcola Avenue

10f. Zip Code: 20902

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Domestic/Own Home

17. Father's Name *(First, Middle, Last)*: John Frank Sharp

18. Mother's Name *(First, Middle, Maiden Surname)*: Leona Smith

19a. Informant's Name/Relationship *(Type, Print)*: Mary Juanita Hayes - Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 11500 Piney Lodge Road, Gaithersburg, MD 20878

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Indianola City Cemetery

Date: 11-14 1998

20c. Location - City or Town, State: Indianola, MS

21. Signature of Funeral Service Licensee: Howard A Carson

22. Name and Address of Facility: Card Funeral Home PO Box 287, Indianola, MS 38751

DMW

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Barry Rosenbaum

29c. License number: D09834

29d. Date signed *(Month, Day, Year)*: Nov 11 1998

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Barry N Rosenbaum Md 3720 Farragut Ave Kensington md 20895

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 16 1998

32. Registrar's Signature: Geneva G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

2 (1)

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37258

RELEASED BY ME

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Louis Anthony Hartman
2. Date of Death Month Dey Yeer: November 12, 1998
3. Time of Death: 8:10 AM
4a. Facility Name *(If not institution, give street and number)*: Suburban Hospital
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-10-5884
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 74 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Dey, Year)*: April 18, 1924
9. Birthplace *(State or Foreign Country)*: Washington, D.C.

Usuel Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 506 Easley street #101
10f. Zip Code: 20910
10g. Citizen of Whet Country?: U.S.A.

11. Merital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Yeer or Dates: 1943-46
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indien, Black, White, etc. Specify: White
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 5+ | College (1-4or 5+):
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Teacher
16b. Kind of Buainess/Industry: Education
17. Father's Name *(First, Middle, Last)*: Frank J. Hartman
18. Mother's Name *(First, Middle, Maiden Surname)*: Johannah T. McAuliffe
19a. Informent's Name/Relationship *(Type, Print)*: Patricia A. Day (sister)
19b. Malling Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 10511 Truxton Road Adelphi, Maryland 20783
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Neme of cemetery, cremetory or other placa)*: Mount Olivet Cemetery
Date: 11/16/98
20c. Location - City or Town, State: Washington, D.C.
21. Signature of Funeral Service Licensee: ▶ Steven D Sipes
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd.,W.,Silver Spring,MD 20901

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Acidosis
Due to (or as a consequence of):
b. RENAL FAILURE
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest
Due to (or as a consequence of):
c. GANGRENE OF LEGS
Due to (or as a consequence of):
d. Thrombosed Aneurysm of Aorta

Part II. **Other significant conditiona** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the ceuse of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No
24b. Were eutopsy findings eveilable prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, offica building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and piece, and due to the ceuse(s) and manner es stated. 2 [ ] **Medicel Examiner:** On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.
29b. Signature end title of certifier: ▶ L. Alberto Nunez, MD
29c. License number: MD-07597
29d. Date signed *(Month, Dey, Yeer)*: 11.12.98
30. Neme end eddress of person who completed cause of death (Item 29e) (Type, Print): L. Alberto Nunez, M.D. 8218 Wisconsin Avenue Bethesda, MD 20814-3107

State Registrar

31. Date filed *(Month, Dey, Yeer)*: NOV 16 1998
32. Registrer's Signeture: ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

HARTMAN, Louis 11-12-98 8:10 AM

20+1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37259

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Daniel Herbert Hart
2. Date of Death (Month, Day, Yeer): November 13, 1998
3. Time of Death: 10:05 a.m.
4a. Facility Name (If not institution, give street end number): 12324 Shadetree Lane
4b. City, Town, or Location of Death: Laurel
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 087-30-7078
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. lest birthday): 70 Yrs.
If Under 1 Year: Months / Deys
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Year): July 16, 1928
9. Birthplece (State or Foreign Country): Czechoslovakia

Usuel Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Laurel
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street end Number: 12324 Shadetree Lane
10f. Zip Code: 20708
10g. Citizen of Whet Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Yeer or Detes: Korean & Viet Nam
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4or 5+): 4
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Mathematician Physicist Analyst
16b. Kind of Business/Industry: U.S. Army

17. Fether's Neme (First, Middle, Last): unavailable
18. Mother's Name (First, Middle, Maiden Surneme): unavailable

19a. Informant's Name/Relationship (Type, Print): Gloria J. Hart (wife)
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 12324 Shadetree Lane, Laurel, Maryland 20708

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removel from State 4 [X] Donation 5 [ ] Other (Specify)
20b. Pleca of Disposition (Name of cemetery, crematory or other pleca): Uniform Services University of Health Sciences
Dete: 11-13
20c. Location - City or Town, Stete: Bethesda, Maryland

21. Signeture of Funeral Service Licensee: Carol a Dehn
22. Name end Address of Fecility: Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, MD 20910

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heert failure. List only one ceuse on eech line.

Approximete Interval Between Onset end Deeth

Immediate Cause (Final disease or condition resulting in death): a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or es a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Last

b. Due to (or as e consequenca of):

c. Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24e. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Were eutopsy findings eveilable prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical exeminer? 1 [X] Yes 2 [ ] No

26. Plece of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residenca 6 [ ] Other (Specify)

27. Manner of Deeth: 1 [X] Natural 2 [ ] Accident 3 [ ] Sulcide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [ ] **Certifying Phyeician:** To the best of my knowledge, deeth occurred et the time, date and place, end due to the ceuse(s) end menner as steted. 2 [X] **Medical Examiner:** On the basis of examination end/or investigation, In my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner stated.

29b. Signeture end title of certifier: [signature] MD
29c. License number: D33957
29d. Date signed (Month, Dey, Year): NOVEMBER 13, 1998

30. Neme end address of person who completed cause of death (Item 23e) (Type, Print): MARIO F. GOLIA JR MD 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785

State Registrar

31. Dete filed (Month, Day, Year): NOV 16 1998
32. Registrer's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28-I show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attanding physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

5 (15)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37260

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Don McClain Harris
2. Date of Death (Month, Day, Year): November 18, 1998
3. Time of Death: 2:30 PM
4a. Facility Name *(If not institution, give street end number)*: 9203 Mintwood Street
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-64-5534
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 52 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Oct. 1, 1946
9. Birthplace *(State or Foreign Country)*: Washington, DC

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 9203 Mintwood Street
10f. Zip Code: 20901
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: Vietnam
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 2
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Computer Information Specialist
16b. Kind of Business/Industry: Bell Atlantic

17. Father's Name *(First, Middle, Last)*: Carl Harris
18. Mother's Name *(First, Middle, Maiden Surname)*: Rachel Thompson

19a. Informant's Name/Relationship *(Type, Print)*: Brenda C. Harris (wife)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 9203 Mintwood Street, Silver Spring, MD 20901

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Chesapeake Crematory
Date: 11-20
20c. Location - City or Town, State: Beltsville, Maryland

21. Signature of Funeral Service Licensee: ▶ Carol A Dahn
22. Name and Address of Facility: Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, Maryland 20910

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death)
a. Metastatic Adenoid Cystic Cancer
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Janet Kaye Oneal DO
29c. License number: H43745
29d. Date signed *(Month, Day, Year)*: November 20, 1998
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Janet Kaye Oneal, D.O., 10301 Georgia Avenue, #301, Silver Spring, MD 20902

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 20 1998
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend #8, 11/18/98, BMW, Montg.Co.

Certificate of Death

Reg. No. 98 37261

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): HERBERT H. HARRIDAY

2. Dete of Deeth — Month: Nov Day: 16, Year: 1998

3. Time of Deeth: 8:05 Am

4e. Facility Name (If not institution, giva street and number): Brooke Grove Rehab And Nursing Cen.

4b. City, Town, or Location of Death: Sandy Spring

4c. County of Deeth: Montgomery

Funeral Director

5. Social Security Number: 218-24-9385

6. Sax: 1☒M 2☐F

7. Aga (In yrs. last birthday): 70 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Dey, Yaar): ~~Oct~~ Oct. 20, 1928

9. Birthplace (Stata or Foreign Country): Maryland

Usual Residence of Decedent

10e. Stete: Md

10b. County: Howard

10c. City, Town or Location: Woodbine

10d. Inside City Limits: 1☒Yes 2☐No

10a. Street end Number: 1963 Daisy Rd,

10f. Zip Code: 21797

10g. Citizen of Whet Country?: U.S.A.

11. Maritel Status: 1☐ Naver Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grede completed): Elementary/Secondary (0-12): 12th Grade; College (1-4or 5+):

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Mechanic

16b. Kind of Business/Industry: Automotive

17. Fathar's Name (First, Middle, Last): Littleton Harriday

18. Mothar's Nama (First, Middle, Maidan Sumema): Hattie Hall

19e. Informant's Name/Relationship (Type, Print): Dana H. Johnson (Daughter)

19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code): 8739 Silent Ct, Odenton, Md #21113

20a. Method of Disposition: ☒Burial 2☐Cremetion 3☐Removal from State 4☐Donetion 5☐Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Daisy Church Cem.

Date: 11/21/98

20c. Location - City or Town, Stata: Woodbine, Md

21. Signature of Funeral Service Licensee: George R. Snowden

22. Neme end Address of Facility: Snowden Funeral Home P.A. 20850 246 N. Washington St, Rockville, Md

Physician /Medical Examiner

23a. Part1. Entar tha diseese, or complications that caused the daath. Do not enter the mode of dying, such es cardiac or respiratory arrast, shock, or heart failure. List only one ceuse on eech line.

Approximete Intervel Between Onsat and Death

Immediate Cause (Final disease or condition resulting in death): a. GLIOBLASTOMA MULTIFORE OF BRAIN — 3 MONTHS

Dua to (or as e consequence of):

Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Lest:

b. Due to (or es a consequence of):

c. Dua to (or as e consequence of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the causa of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings aveileble prior to completion of causa of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Dete of Injury (Month, Day Yaar)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Straet and Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred et the time, dete end place, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the besis of examinetion end/or investigation, in my opinion, deeth occurred st the time, date end place, end due to the cause(s) end manner stated.

29b. Signature end title of certifier

29c. License number: D25947

29d. Dete signed (Month, Dey, Yaar): NOVEMBER 16, 1998

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): EVELYN JOHNSON, MD 5540 TEN OAKS RD, CLARKSVILLE MD 21029

State Registrar

31. Dete filed (Month, Day, Yaar): NOV 18 1998

32. Registrar's Signeture: D. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requiras that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37262

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lurlean Harding

2. Date of Death (Month, Day, Year): Nov 10 1998

3. Time of Death: 8:35PM

4a. Facility Name (If not institution, give street and number): Southern Maryland Hospital Center

4b. City, Town, or Location of Death: Clinton, MD

4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 430-44-6032

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 07-12-1921

9. Birthplace (State or Foreign Country): Arkansas

Usual Residence of Decedent

10a. State: MD

10b. County: P.G.

10c. City, Town or Location: Suitland, Maryland

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 3415 Navy Drive

10f. Zip Code: 20746

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forcas? 1☐ Yes 2☐ No If Yes, Give Year or Dates: No

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Rece - American Indien, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): Luther Fulce

18. Mother's Name (First, Middle, Maiden Surname): Alvain Phillips

19a. Informent's Name/Relationship (Type, Print): Gail D. Wiggins (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3415 Navy Dr. Suitland, MD 20746

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donelion 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Cedar Hill Cemetery | Date: 11/17/98

20c. Location - City or Town, State: Suitland, MD

21. Signature of Funeral Service Licensee: Penny A. Austin

22. Name and Address of Facility: Austin Royster Funeral Home 3821 14th St. NW Wash, D.C. 20011

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. MYOCARDIAL INFARCTION - SHOCK SYNDROME	15 DAYS
Due to (or as a consequence of):	b. ATHEROSCLEROTIC HYPERTENSIVE	YEARS
Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c. CARDIOVASCULAR DISESE	
Due to (or es a consequence of):	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

END STAGE RENAL DISEASE

PERIPHERAL VASCULAR DISEASE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of causa of death? 1☐ Yas 2☐ No

25. Was casa referred to medicat examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Data of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1☐ Yas 2☐ No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To tha best of my knowledge, death occurred at the tima, data and place, and dua to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the causa(s) and manner stated.

29b. Signature and title of certifier: Pamela Guha MD

29c. License number: D 16116

29d. Date signed (Month, Day, Year): 12th Nov. 1998

30. Name end address of person who completed cause of death (Item 23a) (Type, Print): PAMELA GUHA 8926 Woodyard Rd. Suite 501 Clinton, MD. 20735

State Registrar

31. Date filed (Month, Day, Year): NOV 16 1998

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 31263

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lucille Henneforth

2. Dete of Deeth: Month November Dey 9 Yeer 1998

3. Time of Death: 5:00 AM

4e. Feciility Neme (If not institution, give street end number): Lorien Nursing Home

4b. City, Town, or Location of Death: Columbia

4c. County of Deeth: Howard

Funeral Director

5. Sociel Security Number: 200-16-7282

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 84 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Dey, Yeer): Aug 1, 1914

9. Birthplece (Stete or Foreign Country): Pennsylvania

Usuel Residence of Decedent

10a. State: Maryland

10b. County: Howard

10c. City, Town or Location: Columbia

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 6334 Cedar Lane

10f. Zip Code: 21044

10g. Citizen of Whet Country?: United States

11. Mertiel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 1☐ Yes 2☒ No Specify:

14. Rece - American Indien, Black, White, etc. Specify: White

15. Decedent's Eduction (Specify only highest grede completed)

Elementery/Secondery (0-12):

College (1-4or 5+): 4

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Teacher

16b. Kind of Business/Industry: Education

17. Fether's Neme (First, Middle, Last): Michael Collins

18. Mother's Name (First, Middle, Meiden Surneme): Lucy Decker

19a. Informent's Neme/Relationship (Type, Print): Richard Henneforth/Son

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 14100 Southwest 44th Miami, Florida 33175

20a. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Name of cemetery, crematory or other piece): Metro Crematory

Dete: 11-10-98

20c. Location - City or Town, State: Catonsville, MD

21. Signeture of Funerel Service Licensee: ▶ Shona A Collins-Witzke

22. Neme end Address of Feciility: Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043

Physician /Medical Examiner

23e. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Interval Between Onset end Death

Immediate Ceuse (Final disease or condition resulting in death) e. Cerebrovascular accident — 2 weeks

Due to (or es e consequence of):

Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Diseese or injury thet initieted events resulting in deeth) Lest

b.

Due to (or as e consequence of):

c.

Due to (or es e consequence of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cauee of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☑ No

24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? 1☐ Yes 2☑ No

25. Wes cese referred to medical examiner? 1☐ Yes 2☑ No

26. Piece of Deeth (Check only one): Hospital: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Deeth: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Yeer)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Physicien:** To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner es steted. 2☐ **Medicel Examiner:** On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner stated.

29b. Signeture end title of certifier: ▶ Pio J. Poblete MD

29c. License number: D50338

29d. Date signed (Month, Dey, Yeer): November 9, 1998

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): Pio L. Poblete MD 11055 Little Patuxent Parkway, Columbia MD, 21044

State Registrar

31. Dete filed (Month, Day, Year): NOV 10 1998

32. Registrer's Signeture: ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37204

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Bernadine M. Jones

2. Date of Death — Month: NOV; Day: 13; Year: 1998

3. Time of Death: 11:52 PM

4a. Facility Name *(If not institution, give street and number)*: St. Agnes Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 579-34-1984

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 86 Yrs.

If Under 1 Year — Months: ; Days:

If Under 24 Hrs. — Hours: ; Min.:

8. Date of Birth *(Month, Day, Year)*: Nov. 9, 1912

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. Stete: MD

10b. County: Baltimore

10c. City, Town or Location: Catonsville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 715 Maiden Choice Lane

10f. Zip Code: 21228

10g. Citizen of Whet Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Raca - American Indien, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grede completed)*

Elementary/Secondary (0-12):

College (1-4or 5+): 5+

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Teacher/Supervisor

16b. Kind of Business/Industry: Montgomery County Public Schools

17. Fether's Neme *(First, Middle, Last)*: Lawrence B. Jones

18. Mother's Name *(First, Middle, Maiden Sumame)*: Lillian E. Nicholson

19e. Informent's Name/Reletionship *(Type, Print)*: William J. English (Exec. of will)

19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 4214 Saul Road, Kensington, MD 20895

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other place)*: Gate of Heaven Cemetery

Date: 11/18/98

20c. Location - City or Town, State: Silver Spring, MD

21. Signeture of Funeral Service Licensee: Steven D Strand

22. Name end Address of Fecility: Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Interval Between Onset end Deeth

Immediate Cause (Final disease or condition resulting in deeth): e. MYOCARDIAL ISCHEMIA — 1 DAY

Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequenca of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveilable prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medicaf examiner? 1☐ Yes 2☒ No

26. Place of Deeth *(Check only one)*: Hospitel: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other *(Specify)*

27. Manner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Pleca of fnjury - At home, farm, street, fectory, offica building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end piece, end due to the ceuse(s) end menner as steted. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) and manner stated.

29b. Signeture end title of certifier: Mandeep Sandhu MD

29c. License number: P10876

29d. Date signed *(Month, Dey, Year)*: NOV 16, 1998

30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print): MANDEEP SANDHU, ST. AGNES HOSPITAL, BALTIMORE, MD

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 17 1998

32. Registrer's Signeture: Denise G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by tha funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene, Baltimore, Maryland 21215-0020

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

NAME BERNADINE M JONES

15

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37265

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: WILLIAM THURBERT JONES, Sr.
2. Deta of Death Month / Day / Year: November 8, 1998
3. Time of Death: 12:30 pm
4a Facility Nama *(If not institution, give street and number)*: Southern Maryland Hospital
4b. City, Town, or Location of Death: Clinton
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 233-12-0074
6. Sex: 1☐M 2☐F — XX
7. Aga *(In yrs. last birthday)*: 83 Yrs.
If Under 1 Year: Months / Deys
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Dey, Year)*: Nov. 10, 1914
9. Birthplace *(Stete or Foreign Country)*: North Carolina

Usual Residence of Decedent

10a. Steta: WV
10b. County: Kanawha
10c. City, Town or Location: Charleston
10d. Inside City Limits: 1☒Yes 2☐No — X
10e. Street and Number: 1041 Bridge Road
10f. Zip Code: 25314
10g. Citizen of Whet Country?: USA

11. Marital Status: 1☐Never Merried 2☐Married — XX 3☐Widowed 4☐Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐Yas 2☐No — XX
If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.)
1☐Yes 2☒No — XX *Specify:*
14. Raca - American Indien, Black, White, etc.
Specify: Black

15. Decedent's Education *(Specify only highest grade completed)*
Elementary/Secondary (0-12):
College (1-4or 5+): 4 years
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Social Worker
16b. Kind of Business/Industry: State Government

17. Fether's Name *(First, Middle, Last)*: Lewis Jones
18. Mother's Neme *(First, Middle, Maiden Surneme)*: Evangeline Vereen

19e. Informent's Neme/Reletionship *(Type, Print)*: William Jones / son
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 1041 Bridge Road Charleston, West Virginia 25314

20a. Method of Disposition: 1☐Burial 2☐Cremation 3☒Removel from Stete — XX 4☐Donetion 5☐Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, crematory or other piece)*: Grand View Memorial Park
Dete: 11/13/98
20c. Location - City or Town, Stete: Dunbar, West Virginia

21. Signature of Funeral Service Licensee: ▶ Guy S. Kyle
22. Neme end Address of Fecility: Donaldson Funeral Home, P.A.
313 Talbott Avenue Laurel, Maryland 20707

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediete Ceuse (Final disease or condition resulting in deeth)
a. Sepsis — 12 days

Due to (or es e consequence of):
b. Wet gangrene of left foot and left leg

Sequentially list conditions, if any, leeding to immediata cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last

Dua to (or as e consequence of):
c. Pneumonia

Dua to (or as e consequence of):
d. Respiratory Failure

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Peripheral Vascular Disease

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No — XX 3☐Probably 4☐Unknown

24a. Wes en eutopsy performed? 1☐Yes 2☒No — X
24b. Were eutopsy findings aveilable prior to completion of cause of death? 1☐Yes 2☒No — X

25. Wes case referred to medical examiner? 1☐Yes 2☒No — XX
26. Place of Deeth *(Check only one)*
Hospitel: 1☒Inpatient — X 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residenca 6☐Other *(Specify)*

27. Manner of Deeth: 1☒Natural — XX 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Dete of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) end menner as stated. — XX
2☐**Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, death occurred et the time, date and piece, and due to fhe cause(s) end menner stated.

29b. Signeture end title of certifier: ▶ Kasuan Kodali
29c. License number: D0023383
29d. Date signed *(Month, Day, Year)*: 11-9-98

30. Neme end address of person who completed cause of deeth (Item 23a) (Type, Print): 7127 Allentown Road Camp Springs, Maryland 20748

State Registrar

31. Dete filed *(Month, Day, Year)*: NOV 12 1998
32. Registrer's Signature: ▶ Jennie G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

4

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37266

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CHARLES ROBERT JEWELL

2. Date of Death: Month NOV. Day 15 Year 1998

3. Time of Death: 8:30 AM

4a. Facility Name (If not institution, give street and number): 10 GRASONVILLE TERRACE

4b. City, Town, or Location of Death: GRASONVILLE

4c. County of Death: QUEEN ANNE

Funeral Director

5. Social Security Number: 218-20-4896

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 71 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 20, 1927

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: QUEEN ANNE

10c. City, Town or Location: GRASONVILLE

10d. Inside City Limits: 1 [X] Yes 2 [ ] No XXX

10e. Street and Number: 10 GRASONVILLE TERRACE

10f. Zip Code: 21638

10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married XX 3 [ ] Widowed 4 [ ] Divorced

12. Wes Decadent Ever in U,S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Detes: WWII

13. Was Decadent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No XX Specify:

14. Rece - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 6

College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Carpenter

16b. Kind of Business/Industry: Building (Various) Contractor

17. Fether's Neme (First, Middle, Last): John Jacob Jewell

18. Mother's Name (First, Middle, Maiden Surname): Barbara Slavisca

19a. Informant's Neme/Relationship (Type, Print): Sandra Higdon (Daughter)

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 15720 Fairhaven Lane, Goldsboro, Md. 21636

20a. Method of Disposition: X [X] Burial 2 [ ] Cremation 3 [ ] Removel from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Piece of Disposition (Name of cemetery, cremetory or other piece): Stevensville Cemetery

Dete: Nov. 18, 1998

20c. Location - City or Town, Stete: Stevensville, Md.

21. Signeture of Funeral Service Licensee: Amy McInerney

22. Name end Address of Fecility: Fellows, Helfenbein & Newnam Funeral Home 106 Shamrock Rd., Chester, Md.

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

		Approximete Interval Between Onset and Death
Immediete Ceuse (Finel disease or condition resulting in deeth) a.	chronic respiratory failure	1yr
Due to (or es e consequence of):		
Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting in death) Lest b.	Emphysema	10 yrs
Due to (or es e consequence of):		
c.		
Due to (or es e consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobecco use contribute to the cauee of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 1 [ ] Yes 2 [X] No

25. Was case referred to medical exeminer? 1 [ ] Yes 2 [X] No

26. Piece of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Phyeician:** To the best of my knowledge, death occurred at the time, dete end place, and due to the ceuse(s) end menner es stated. 2 [ ] **Medical Examiner:** On the basis of examination end/or Investigetion, in my opinion, death occurred et the time, date and place, and due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier: [illegible]

29c. License number: D44749

29d. Date signed (Month, Dey, Yeer): 11/16/98

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print): PETER L. WHITESELL, M.D., 508 IDLEWILD AVENUE, EASTON, MD 21601

State Registrar

31. Dete filed (Month, Day, Year): NOV 18 1998

32. Registrer's Signeture: Geneva G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37267

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Lelia King
2. Date of Death (Month, Day, Year): November 14 1998
3. Time of Death: 1325
4a. Facility Name *(If not institution, giva street and number)*: PENINSULA REGIONAL MEDICAL CENTER
4b. City, Town, or Location of Death: SALISBURY
4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 254-18-5717
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 78 Yrs.
If Under 1 Yaar: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: MAY 29 1920
9. Birthplaca *(Stata or Foreign Country)*: GEORGIA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: Wicomico
10c. City, Town or Location: Salisbury
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1204 Flamingo Dr.
10f. Zip Code: 21801
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yas, Giva Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 6; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Giva kind of work done during most of working life. DO NOT use retired)*: food processing
16b. Kind of Business/Industry: Dulany Foid

17. Fathar's Name *(First, Middle, Last)*: Hillard Morland
18. Mother's Nama *(First, Middla, Maiden Surname)*: Ida Morland

19a. Informant's Name/Relationship *(Type, Print)*: Isabell Baker Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1204 Flamingo Dr. Salisbury md. 21801

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Spring Hill Cemetery
Date: 11/21/98
20c. Location - City or Town, State: Hebron md.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Brown Smith F/H Ocean Gate Hwy Salisbury md.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not entar tha mode of dying, such as cardiac or raspiratory arrest, shock, or heart feilure. List only one ceuse on eech line.

Approximate Intervel Between Onset and Death

Immediate Cause (Final disaese or condition resulting in deeth)
a. Asystole — minutes

Due to (or as a consequenca of):
b. Atherosclerotic Cardiovascular Ds — 16 yrs

Sequantially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequenca of):
c.

Due to (or as a consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Type II Diabetes mellitus
Left Ventricular Hypertrophy
Carotid Artery occlusive ds.

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performad? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of daath? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Placa of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☒ DOA Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, offica building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) and menner as steted. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to tha cause(s) and manner stated.
29b. Signature and title of certifier: [signature] mo
29c. License number: D24986
29d. Date signed *(Month, Day, Year)*: 11/16/98
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Robert J. Reilly mo 106 Milford St. Salisbury md. 21804

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 20 1998
32. Registrar's Signatura: [signature] G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

permit. Peges 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours efter death.
To the Funeral Director: After this certificate has been signed by the attanding physician and completely fillad in by the funeral director, page 2 should be detached for use as the burial-transit

254-18-5717
Lelia T. King
4

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37260

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Raisa Kostiuk
2. Date of Death (Month, Day, Year): NOVEMBER 8, 1998
3. Time of Death: 11:18 P.M.
4a. Facility Name (If not institution, give street and number): 3603 SOUTH LEISURE WORLD BLVD.
4b. City, Town, or Location of Death: SILVER SPRING
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 068-28-2867
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): August 12,1915
9. Birthplace (State or Foreign Country): Ukraine

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☐ No
10e. Street and Number: 3603 S. Leisure World Blvd.
10f. Zip Code: 20906
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Watch Dial Artist
16b. Kind of Business/Industry: Jewelry

17. Father's Name (First, Middle, Last): Oleksandr Butko
18. Mother's Name (First, Middle, Maiden Surname): Uliana Kovalevska

19a. Informant's Name/Relationship (Type, Print): Theodor Kostiuk/Mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6703 96th Place Seabrook,MD 20706

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): St. Andrew's Ukrainian | Data: 11/11/98
20c. Location - City or Town, State: South Boundbrook,NJ

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: HINES RINALDI FUNERAL HOME,INC. 11800 New Hampshire Ave. Silver Spring.MD 20904

Dead

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset end Death

Immediate Cause (Finel disease or condition resulting in death): e. Alzheimers Disease — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
Due to (or as e consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] M.D.
29c. License number: D 06381
29d. Data signed (Month, Day, Year): November9,1998
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Benjamin Avrunin,M.D. 18111 Prince Phillip Dr. #209 Olney,MD 20832

State Registrar

31. Date filed (Month, Day, Year): NOV 16 1998
32. Registrar's Signature: [signature] G. Sparks

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4 (4)

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37269

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Beverly Ann Kallfelz
2. Dete of Deeth — Month: November, Dey: 18, Yeer: 1998
3. Time of Death: 5:05 AM
4a Facility Nama *(If not institution, giva street and number)*: Holy Cross Hospital
4b. City, Town, or Location of Death: Silver Spring
4c. County of Deeth: Montgomery

Funeral Director

5. Social Security Number: 101-26-5307
6. Sax: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 65 Yrs. — If Under 1 Year: Months / Deys; If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Dey, Year)*: August 22, 1933
9. Birthplace *(State or Foraign Country)*: New York

Usual Residence of Decedent

10a. Stete: Maryland
10b. County: Montgomery
10c. City, Town or Location: Potomac
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 11513 Regency Drive
10f. Zip Code: 20854
10g. Citizen of Whet Country?: United States
11. Maritel Status: 1☐ Never Married 2☐ Merried 3☐ Widowed 4☒ Divorced
12. Was Decedant Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yas, Giva Year or Detes:
13. Wes Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Reca - American Indian, Black, Whita, etc. *Specify:* White
15. Decedent's Education *(Specify only highast grade complatad)*: Elementary/Secondary (0-12): – ; College (1-4or 5+): 4
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home
17. Fether's Nama *(First, Middla, Last)*: Donald Bishop
18. Mothar's Neme *(First, Middle, Maiden Surnema)*: Louise Stahoski
19a. Informent's Name/Reletionship *(Type, Print)*: Chris P. Kallfelz/ Son
19b. Mailing Address *(Street end Number or Rurel Routa Number, City or Town, Stete, Zip Code)*: 1225 Rome Corners Road, Galena, Ohio 43021
20e. Method of Disposition: 1☐ Burial 2☒ Cramation 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, cremetory or other pleca)*: Montgomery Crematorium, Inc. Date: November 20, 1998
20c. Location - Clty or Town, Steta: Bethesda, Maryland
21. Signature of Funeral Service Licensee: MD0689
22. Name end Address of Fecility: Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complicetions that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one ceuse on eech line.

		Approximate Intervel Between Onset and Death
Immediata Cause (Final disease or condition resulting in death) e.	Cerebrovascular Accident	1 week
	Dua to (or as a consequance of):	
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Lest b.		
	Due to (or es e consequenca of):	
c.		
	Due to (or as a consequenca of):	
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was en eutopsy performad? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical exeminer? 1☐ Yes 2☒ No

26. Place of Deeth *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other *(Specify)*

27. Manner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner**: On the basis of exemination end/or investigation, in my opinion, deeth occurred at the time, dete end placa, end due to the cause(s) and manner steted.

29b. Signeture end title of certifier: MD
29c. Licensa number: D34032
29d. Data signed *(Month, Dey, Year)*: 11/18/98

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print): JEANNE P. ASNER, MD 3720 FARRAGUT AVE KENSINGTON MD 20895

State Registrar

31. Date filed *(Month, Dey, Year)*: NOV 20 1998
32. Registrar's Signetura: D. Sparks

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after deeth.
To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37270

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Elizabeth H. Kemon
2. Date of Death (Month, Day, Year): November 17, 1998
3. Time of Death: 5:26PM
4a. Facility Name *(If not institution, give street and number)*: Suburban Hospital
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-24-8788
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 80 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Feb. 25, 1918
9. Birthplace *(State or Foreign Country)*: New York

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Chevy Chase
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 4008 Virgilia Street
10f. Zip Code: 20815
10g. Citizen of What Country?: United States
11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home
17. Father's Name *(First, Middle, Last)*: Norman B. Hall
18. Mother's Name *(First, Middle, Maiden Surname)*: Elizabeth Hamilton
19a. Informant's Name/Relationship *(Type, Print)*: Solon B. Kemon / husband
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4008 Virgilia Street, Chevy Chase, MD 20815
20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Montgomery Crematorium, Inc. | Date: November 19, 1998
20c. Location - City or Town, State: Bethesda, Maryland
21. Signature of Funeral Service Licensee: Barbara J. McMullen Lawrence M00831
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Cardiac Arrest — Minutes

Due to (or as a consequence of):
b. Myocardial Infarction — Minutes

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Penelope Friedman MD
29c. License number: D0051271
29d. Date signed *(Month, Day, Year)*: November 19, 1998
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Penelope Friedman, M.D. 5401 Western Avenue, NW, Washington, DC 20015

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 20 1998
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

ELIZABETH H. KEMON

20

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37271

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Selwa Jeha Khalidi
2. Dete of Deeth — Month: November Day: 12 Year: 1998
3. Time of Death: 9:40 AM
4a Fecility Name *(If not institution, give street end number)*: 4515 Willard Avenue #2014 South
4b. City, Town, or Location of Deeth: Chevy Chase
4c. County of Deeth: Montgomery

Funeral Director

5. Social Security Number: 102-14-1340
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 82 Yrs.
If Under 1 Year: Months / Deys
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Dey, Yeer)*: November 9, 1916
9. Birthplece *(Stete or Foreign Country)*: Lebanon

Usuel Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Chevy Chase
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 4515 Willard Avenue #2014S
10f. Zip Code: 20815
10g. Citizen of Whet Country?: United States

11. Marital Status: 1☐ Never Merried 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - Americen Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grede completed)*: Elementery/Secondary (0-12) / College (1-4or 5+): 4
16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Interior Decorator
16b. Kind of Business/Industry: Decorating

17. Father's Name *(First, Middle, Last)*: Antonius Jeha
18. Mother's Name *(First, Middle, Maiden Surname)*: Helena Jeha

19e. Informent's Name/Relationship *(Type, Print)*: Rashid Khalidi/Son
19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 5505 S. Kimbark Avenue, Chicago, Illinois 60637

20a. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, cremetory or other place)*: Montgomery Crematorium, Inc. Date: November 16, 1998
20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service Licensee: ▶ Michael E. Hagen M00846
22. Name end Address of Fecility: Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on eech line.

Approximete Intervel Between Onset end Death

Immediate Cause (Final disease or condition resulting in death)
e. Atherosclerotic Cardiovascular Disease — 3 years

Due to (or as e consequence of):

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Lest
b. Diabetes

Due to (or es e consequence of):
c. Weight Loss

Due to (or as e consequence of):
d.

Pert II. **Other significent conditions** contributing to deeth but not resulting in the underlying ceuse given in Part I.

23b. **Did tobecco use contribute to the cauee of death?** 1☐ Yee 2☒ No 3☐ Probably 4☐ Unknown

24a. Was en eutopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Wes cese referred to medicel examiner? 1☒ Yes 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Date of Injury *(Month, Dey Year)*
28b. Time of Injury
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Phyeician:** To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) and manner es steted. 2☐ **Medicel Examiner:** On the basis of examination end/or investigation, In my opinion, deeth occurred et the time, date end piece, end due to the cause(s) and manner stated.

29b. Signature end title of certifier: ▶ Ace Lipson M.D.
29c. License number: D19955
29d. Date signed *(Month, Day, Yeer)*: November 12, 1998

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): Ace Lipson, M.D. 2141 K Street, N.W. Washington, D.C. 20037

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 16 1998
32. Registrer's Signeture: Brenda B. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attanding Physician: Tha law requiras thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37272

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Evelyn Conant King
2. Data of Death Month Day Year: Nov 16,1998
3. Time of Death: 11:15pm
4a. Facility Name *(If not institution, give street and number)*: Holy Cross Hospital
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 222-07-9653
6. Sex: 1☐M 2☒F
7. Age *(In yrs. last birthday)*: 80 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: June 23, 1918
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedant

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 10619 Ordway Drive
10f. Zip Code: 20901
10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): — College (1-4or 5+): 4
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Teacher
16b. Kind of Business/Industry: Education

17. Father's Name *(First, Middle, Last)*: Daniel Gilbert Conant
18. Mother's Name *(First, Middle, Maiden Surname)*: Vera Wilhemina Bubert

19a. Informant's Name/Relationship *(Type, Print)*: Evelyn Bozinko (daughter)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 13908 Shippers Lane, Rockville, MD 20853

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*
20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Gate of Heaven Cemetery
Data: 11/20/98
20c. Location - City or Town, State: Silver Spring, MD

21. Signature of Funeral Service Licensee: James E. Dooley
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CANCER OF the lung — 6 months
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death *(Check only one)*: Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA — Other: 4☐Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Alan Weinstock MD
29c. License number: D09748 MD
29d. Date signed *(Month, Day, Year)*: Nov 17 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Alan R.Weinstock MD 10313 Georgia Ave Silver Spring Md 20902

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 18 1998
32. Registrar's Signature: Geneva G. Apostol

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37273

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Diane Lee Kline

2. Date of Death (Month, Day, Year): November 16, 1998

3. Time of Death: 9:20am

4e. Facility Name (If not institution, give street and number): 13 Redgate Court

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 206-42-8637

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 47 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 31, 1951

9. Birthplace (State or Foreign Country): PA

Usual Residence of Decedent

10a. State: MD

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 13 Redgate Court

10f. Zip Code: 20905

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4or 5+): 1

16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): Home maker

16b. Kind of Business/Industry: own home

17. Father's Neme (First, Middle, Last): Robert Kaufman

18. Mother's Name (First, Middle, Maiden Surname): Elaine Grode

19a. Informent's Name/Relationship (Type, Print): Melvin Kline-spouse

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 13 Redgate Ct. Silver Spring, MD 20905

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Placa of Disposition (Name of cemetery, crematory or other place): Judean Memorial Gardens

Date: 11/17/98

20c. Locatlon - City or Town, State: Olney, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility: Danzansky-Goldberg Memorial Cahpels, Inc. 1170 Rockville Pike Rockville MD 20852

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Finel disease or condition resulting In death)

a. Metastatic Breast Cancer — 4 yrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest

b. Due to (or as e consequenca of):

c. Due to (or es e consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given In Part I.

23b. Did tobacco uee contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as steted. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of cartifier

29c. License number: D33293

29d. Date signed (Month, Day, Year): 11-16-98

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): Frances Smith 5401 Western Ave Washington DC

State Registrar

31. Date filed (Month, Day, Year): NOV 17 1998

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: Tha law requiras thet the death certificata be axecuted within 24 hours after death.

To the Funeral Director: Aftar this cartificate has been signed by tha attending physician and completely filled in by tha funaral director, page 2 should be datechad for usa as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37274

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Irvin KING, Jr.

2. Date of Death (Month, Day, Year): November 16, 1998

3. Time of Death: 7:00 am

4a. Facility Name *(If not institution, give street and number)*: Mariner Health of Mt. Clare

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: -

Funeral Director

5. Social Security Number: 214 24 3270

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 73 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: April 24, 1925

9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD

10b. County: -

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 3129 Wilkins Avenue

10f. Zip Code: 21223

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No. If Yes, Give Year or Dates: 1945-46

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 3 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: truck driver

16b. Kind of Business/Industry: construction

17. Father's Name *(First, Middle, Last)*: Irving King, Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Minnie Mae King

19a. Informant's Name/Relationship *(Type, Print)*: Diana L. Grewe/daug.

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2828 Alabama Ave., Balt., MD 21227

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: St. James Epis. Cem.

Date: 11-20-98

20c. Location - City or Town, State: Lothian, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Rausch Funeral Home, Owings, MD 20736

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. CORONARY ARTERY DISEASE — 1996

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic Renal Failure

Chronic Obstructive Lung Disease

Dementia - Multiinfarct

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [X] Nursing Home 5 [ ] Residence 8 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D 14622

29d. Date signed *(Month, Day, Year)*: Nov. 18, 1998

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): H.L. Muncie, Jr. M.D. 29 S. Paca St., Balt., MD 21201

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 20 1998

32. Registrar's Signature: [signature]

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

8

1 VA

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / ~~Department~~ of Health and Mental Hygiene 98 37275

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Jocelyn Louise KELLUM
2. Date of Death Month / Day / Year: Nov. 14, 1998
3. Time of Death: 1:10AM
4a. Facility Name *(If not institution, give street and number)*: Rte. #301 & Haden Clark Road
4b. City, Town, or Location of Death: Centreville
4c. County of Death: Queen Anne's

Funeral Director

5. Social Security Number: 219-88-8760
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 35 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Aug. 29, 1963
9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD
10b. County: Queen Anne's
10c. City, Town or Location: Queen Anne
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1121 Damsontown Road
10f. Zip Code: 21657
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker/ Dog Groomer
16b. Kind of Business/Industry: Self and Breeders Best

17. Father's Name *(First, Middle, Last)*: John Parson
18. Mother's Name *(First, Middle, Maiden Surname)*: Florence Cullum

19a. Informant's Name/Relationship *(Type, Print)*: William H. Kellum, Jr/Husband
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1121 Damsontown Rd. Queen Anne, MD 21657

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Chesapeake Cremation Center
Date: Nov. 15, 1998
20c. Location - City or Town, State: Stevensville, MD

21. Signature of Funeral Service Licensee: Amy L. Michaels
22. Name and Address of Facility: Fellows, Helfenbein & Newnam Funeral Home 408 S. Liberty St. Centreville, MD 21617

Physician /Medical Examiner

23a. Part I. Enter the disease(s) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Probable Cervical Fracture — IMMEDIATE
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* at scene 301 Hwy.

27. Manner of Death: 1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*: Nov. 14, 1998
28b. Time of Injury: 1:10A M
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: (Thrown from auto) Auto accident
28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: 301 Hwy at Rest Stop
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: Near Price, MD

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Ralph E. Libby
29c. License number: D0005754
29d. Date signed *(Month, Day, Year)*: 11-16-98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Ralph E. Libby 204 Medical Center Road Grasonville, MD 21638

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 16 1998
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37276

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: HOMER LEE LEWIS
2. Deta of Deeth — Month: 11 Day: 18 Year: 98
3. Time of Death: 8:30 AM
4a Facility Name *(If not institution, giva street end number)*: 8524 Old Ocean City RD
4b. City, Town, or Location of Death: Berlin
4c. County of Deeth: Worcester

Funeral Director

5. Social Security Number: 218-34-9801
6. Sex: 1 ☒ M 2 ☐ F
7. Age *(In yrs. last birthdey)*: 61 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Dey, Yeer)*: 7/13/37
9. Birthplace *(Stata or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD
10b. County: Worcester
10c. City, Town or Location: Berlin
10d. Inside City Limits: 1 ☐ Yas 2 ☒ No
10e. Street end Number: 8524 Old Ocean City RD
10f. Zip Code: 21811
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. Wes Decedent Ever in U.S. Armed Forcas? 1 ☐ Yes 2 ☒ No — If Yas, Giva Yaer or Detas:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puerto Ricen, etc.): 1 ☐ Yes 2 ☒ No *Specify:*
14. Race - Americen Indien, Bleck, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest greda completad)*: Elementary/Secondary (0-12): 7 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Farmer
16b. Kind of Business/Industry: Poultry

17. Fether's Neme *(First, Middle, Last)*: Reese Lewis
18. Mother's Name *(First, Middle, Maiden Sumema)*: Beatrice Wilkins

19a. Informent's Neme/Reletionship *(Type, Print)*: Steve Lewis/ Son
19b. Meiling Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 8510 Old Ocean City RD Berlin, MD 21811

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cramation 3 ☐ Remaval from Stata 4 ☐ Donetion 5 ☐ Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Willards Cemetery
Dete: 11/21/98
20c. Location - City or Town, Stete: Willards, MD

21. Signature of Funeral Service Licensee: W. Eric Burbage
22. Name end Address of Facility: Burbage Funeral Home, 108 William St. Berlin, MD 21811

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Myocardial Infarction
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last: b. Congestive Heart Failure
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Wes an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of ceuse of death? 1 ☐ Yes 2 ☐ No

25. Was cese referred to medical exeminer? 1 ☐ Yas 2 ☒ No
26. Piece of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Hema 5 ☒ Residence 6 ☐ Other *(Specify)*

27. Menner of Death: 1 ☒ Naturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury et Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, end due to the ceuse(s) and manner es steted.
2 ☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: Benjamin H Meyer
29c. Licensa number: D30743
29d. Date signed *(Month, Dey, Year)*: 11/18/98

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print): Benjamin H. Meyer, MD 314 Franklin Ave. Berlin, MD 21811

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 20 1998
32. Registrar's Signature: Geneva D. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37277

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Foreman Lockwood

2. Date of Death (Month, Day, Year): November 18, 1998

3. Time of Death: 2:30 AM

4a. Facility Name (If not institution, give street and number): Salisbury Center: Genesis ElderCare

4b. City, Town, or Location of Death: Salisbury, MD

4c. County of Death: Wicomico

Funeral Director

5. Social Security Number: 218-20-5189

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 73 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 5-29-25

9. Birthplace (State or Foreign Country): DE.

Usual Residence of Decedent

10a. State: MD

10b. County: Worcester

10c. City, Town or Location: Newark

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 8386 Pateywoods Rd.

10f. Zip Code: 21841

10g. Citizen of What Country?: U.S.A.

11. Meritel Stetus: 1 [ ] Nevar Merried 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forcas? 1 [ ] Yas 2 [X] No If Yes, Give Yaar or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yas 2 [X] No Specify:

14. Race - Americen Indian, Black, White, atc. Specify: Black

15. Decedent's Educetion (Specify only highest grade completed): 3rd

Elementary/Secondary (0-12) / Collega (1-4or 5+)

16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired): Chicken catcher

16b. Kind of Businass/Industry: Poultry

17. Father's Nama (First, Middle, Last): Henry Lockwood

18. Mothar's Nama (First, Middle, Maiden Surnama): Teng Foreman

19a. Informant's Name/Relationship (Type, Print): Hazel Lockwood-wife

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code): 8386 Pateywood Rd. Newark Md. 21841

20a. Mathod of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Othar (Specify)

20b. Place of Disposition (Name of cematary, cramatory or other place): Williams A.M.E. Cemetary

Data: 11-21-98

20c. Location - City or Town, Stata: Newark md, 21841

21. Signature of Funeral Service Licensee: John A. Prince

22. Nama and Address of Facility: Bennie Smith Funeral Home P.O. Box 331 Pocomoke City md. 21851

Physician /Medical Examiner

23a. Part1. Enter tha diseesa, or complications that caused the death. Do not antar tha moda of dying, such as cardiac or raspiratory erreet, shock, or haart failura. List only ona cause on aach lina.

Approximata Interval Between Onset and Death

Immediata Causa (Final diseasa or condition resulting in death)

e. Atherosclerotic VAScular Disease

Due to (or as e consequence of):

Sequantially list conditions, if eny, leading to immediate causa. Entar Undarlying Causa (Diseasa or Injury that initiated evants resulting in daath) Last

b. Blast leg Amputations, Strokes - years

Due to (or as e consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha undarlying cause given in Part I.: Diabetes Mellitus; Renal Failure on Dialysis

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was en autopsy performed? 1 [ ] Yas 2 [X] No

24b. Wara autopsy findings eveilable prior to completion of cause of death? 1 [ ] Yas 2 [X] No

25. Wes casa rafarred to medical examiner? 1 [ ] Yes 2 [X] No

26. Placa of Death (Check only ona): Hospital: 1 [ ] Inpatiant 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Homa 5 [ ] Residence 6 [ ] Othar (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicida 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Data of Injury (Month, Day Year)

28b. Tima of Injury

28c. Injury at Work? 1 [ ] Yas 2 [ ] No

28d. Describe how injury occurred

28a. Placa of Injury - At home, farm, street, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledga, death occurred at the time, data and placa, and due to tha causa(s) and mannar as stated. 2 [ ] **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and placa, and due to tha causa(s) and mannar statad.

29b. Signatura and title of certifier: MD

29c. Licensa number: D39813

29d. Date signed (Month, Day, Year): 11/18/98

30. Nama and eddrass of person who complatad causa of daath (Item 23a) (Type, Print): MARKINS MD 104 Healthway Drive Salis, MD 21804

3

State Registrar

31. Data filed (Month, Day, Year): NOV 24 1998

32. Registrer's Signatura: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

98-6518-031
crn
Bruce Lambert Lee
Amend #7 & 10e,11/17/98,BMW,Montg.Co.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37279

Physician / Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Data of Death Month Day Yaar	3. Tima of Death
Bruce Lambert Lee	November 09, 1998	3:07 P.M.

4a Facility Nama (If not institution, giva street and number)	4b. City, Town, or Location of Death	4c. County of Death
1608 South Springwood Drive	Silver Spring	Montgomery

Funeral Director

5. Social Security Number	6. Sax	7. Aga (In yrs. last birthday)	If Undar 1 Yaar: Months / Days	If Undar 24 Hrs.: Hours / Min.	8. Data of Birth (Month, Day, Yaar)	9. Birthplaca (Stata or Foraign Country)
577-64-8209	1[X] M 2[ ] F	~~52~~ 51 Yrs.			Dec. 10, 1946	Indiana

Usual Rasidance of Dacedant

10a. Stata	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Silver Spring	1[ ] Yas 2[X] No

10e. Street and Number	10f. Zip Coda	10g. Citizen of Whet Country?
1608 South Springwood Drive ~~1608 Springwood Drive~~	20910	United States

11. Marital Status	12. Was Decedent Evar in U.S. Armed Forcas?	13. Was Dacedent of Hispanic Origin? (Specify Yas or No- It Yas, specify Cuban, Maxican, Puarto Rican, atc.)	14. Race - Amaricen Indian, Black, Whita, atc.
1[ ] Navar Marriad 2[ ] Married 3[ ] Widowed 4[X] Divorced	1[ ] Yas 2[X] No It Yas, Giva Yaar or Datas:	1[ ] Yas 2[X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Businass/Industry
Elamantary/Secondary (0-12)	College (1-4or 5+)		
	4	Roofing Contractor	Self Employed

17. Fathar's Nama (First, Middle, Last)	18. Mothar's Nama (First, Middla, Maidan Surnama)
Delbert Lambert Lee	Mary Blakeman Smith

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Streat and Number or Rural Route Number, City or Town, State, Zip Code)
Jaime M. Lee (brother)	125 Crystal Spring Drive, Ashton, Maryland 20861

20a. Mathod of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Data	20c. Location - City or Town, Stata
1[ ] Burial 2[X] Cramation 3[ ] Ramoval from Stata 4[ ] Donation 5[ ] Othar (Specify)	Chesapeake Crematory	11-11-98	Beltsville, Maryland

21. Signatura of Funaral Sarvica Licansaa	22. Nama and Addrass of Facility
Carol A Dahn	Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, Maryland 20910

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician / Medical Examiner

23a. Part1. Entar tha disaasa, or complications that causad tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart tailure. List only ona causa on aach lina.

Approximata Intarval Batwaan Onsat and Daath

Immediata Causa (Final disaasa or condition resulting in death)

a. Pulmonary Thromboembolism due to Deep Vein Thrombosis

Due to (or as e consequence of):

Sequantially list conditions, if any, laading to immadieta ceusa. Entar Undarlying Ceusa (Disaasa or injury that initiated avants rasulting in daath) Last

b. Dua to (or as a consequance of):

c. Dua to (or as a consequance of):

d.

Part II. **Othar afgnifitcant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.

23b. Did tobacco usa contributa to tha causa of death? 1[ ] Yes 2[ ] No 3[ ] Probably 4[X] Unknown

24a. Was an autopsy performed?	24b. Wara autopsy findings availabla prior to compilation of ceusa of daath?
1[X] Yas 2[ ] No	1[X] Yas 2[ ] No

25. Wes casa retarrad to medical examinar?	26. Placa of Daath (Check only one)	
1[X] Yas 2[ ] No	Hospital: 1[ ] Inpatient 2[ ] ER/Outpatient 3[ ] DOA	Othar: 4[ ] Nursing Home 5[X] Rasidence 6[ ] Othar (Specify)

27. Manner of Deeth	28a. Date of Injury (Month, Day Yaar)	28b. Tima of Injury	28c. Injury at Work?	28d. Dascribe how injury occurred
1[X] Naturel 2[ ] Accident 3[ ] Suicida 4[ ] Homicida 5[ ] Panding Invastigation 6[ ] Could not be determined		M	1[ ] Yas 2[ ] No	

28a. Plece of Injury - At homa, tarm, straat, tactory, office building, atc. (Specify)	28f. Location (Straet and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifiar (Check only one) 1[ ] **Certifying Physician:** To tha best of my knowledga, daath occurrad at tha tima, date and plece, and due to tha cause(s) and mannar as stated. 2[X] **Medical Examinar:** On tha basis of examination and/or investigation, in my opinion, daath occurrad at tha tima, data and place, and dua to tha causa(s) and mannar statad.

29b. Signatura and titla of certifiar	29c. Licansa number	29d. Data signed (Month, Day, Yaar)
Theodore M. King MD	O.C.M.E.	NOVEMBER 12, 1998

30. Nama and addrass of person who completed causa of deeth (Itam 23a) (Type, Print)

THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Data filed (Month, Day, Yaar)	32. Registrar's Signatura
NOV 17 1998	Geneva B. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37279

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GEORGE R. LYONS
2. Date of Death (Month, Day, Year): NOV. 17, 1998
3. Time of Death: 7:05 AM
4e. Facility Name (If not institution, give street and number): WOODSIDE CENTER-GENESIS ELDERCARE
4b. City, Town, or Location of Death: SILVER SPRING
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 214-30-1597
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 71 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JAN. 7, 1927
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. Stete: MD.
10b. County: MONTGOMERY
10c. City, Town or Location: SILVER SPRING
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 2006 LUZERNE AVE.
10f. Zip Code: 20910
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CREDIT MANAGER
16b. Kind of Business/Industry: LUMBER CO.
17. Father's Name (First, Middle, Last): ROBERT LYONS
18. Mother's Name (First, Middle, Maiden Surname): MARY ANN MUNDAY
19a. Informant's Name/Relationship (Type, Print): GENNARO J. CHIRICHELLA/FRIEND
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8201 16th ST.#106, SILVER SPRING, MD. 20910
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ROCK CREEK CEMETERY
Date: 11/20/98
20c. Location - City or Town, State: WASHINGTON, D.C.
21. Signature of Funeral Service Licensee: W.W. Chambers M00091
22. Name and Address of Facility: CHAMBERS FUNERAL HOMES, P.A. SILVER SPRING, MD. 20910

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Respiratory Insufficiency — Days
Due to (or as a consequence of):
b. Pneumonia — Days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Stroke — weeks
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residenca 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. 2 [ ] **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date and placa, and due to the cause(s) and manner stated.
29b. Signature and title of cartifier: M. Mehrotra MD
29c. License number: D-32332
29d. Date signed (Month, Day, Year): 11/17/98
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SK Gupta MD 9801 Georgia Ave, #220 silver Spring MD 20902

State Registrar

31. Date filed (Month, Day, Year): NOV 18 1998
32. Registrar's Signature: Geneva G. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

parmit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: Tha law requiras that tha death certificata be executed within 24 hours after death.
To the Funeral Director: Aftar this certificata has been signed by tha attanding physician and completely filled in by the funaral director, paga 2 should be detached for usa as tha burial-transit

10

DHMH 16 Rev 6/95

98-6546-025
crn
Paul Lydon

ITEMS: #23 PART I, 27 PER MEO G766 12-15-98 WR.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

98 37280

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Paul J. Lydon

2. Date of Death — Month: November; Day: 11; Year: 1998

3. Time of Death: 4:25 A.M.

4a. Facility Name *(If not institution, give street and number)*: Fallston General Hospital

4b. City, Town, or Location of Death: Fallston

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 154-40-2229

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 50 Yrs.

If Under 1 Year — Months: ; Days:

If Under 24 Hrs. — Hours: ; Min.:

8. Date of Birth *(Month, Day, Year)*: August 21, 1948

9. Birthplace *(State or Foreign Country)*: Bronx, NY

Usual Residence of Decedent

10a. State: New York

10b. County: Orange

10c. City, Town or Location: Town of Goshen

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 5 Redwood Drive

10f. Zip Code: 10924

10g. Citizen of What Country?: United States of America

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1967-1971 Vietnam

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education *(Specify only highest grade completed)*

Elementary/Secondary (0-12):

College (1-4or 5+): 2

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Electrician

16b. Kind of Business/Industry: Middletown Public School

17. Father's Name *(First, Middle, Last)*: Luke Lydon

18. Mother's Name *(First, Middle, Maiden Surname)*: Victoria Catona

19a. Informant's Name/Relationship *(Type, Print)*: Mrs. Elizabeth A. Lydon - Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5 Redwood Srive Goshen, New York 10924

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, cremetory or other place)*: St. Columbia Cemetery

Date: Nov. 16, 1998

20c. Location - City or Town, State: Chester, New York

21. Signature of Funeral Service Licensee: Karen W. Doyle

22. Name and Address of Facility: Donovan Funeral Home 82 S. Church Street Goshen, New York 10924

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CARDIAC ARRHYTHMIA

Due to (or as a consequence of):

WOLFF-PARKINSON-WHITE SYNDROME AND FOCAL MYOCARDIAL FIBROSIS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No

26. Place of Death *(Check only one)*

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury: M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*

1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Wayne Buelfuss

29c. License number: O.C.M.E.

29d. Date signed *(Month, Day, Year)*: November 12, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARGARITA A. KORENEV 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 16 1998

32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37201

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Casimir Lotarski
2. Date of Death (Month, Day, Year): November 15, 1998
3. Time of Death: 9:40 A.M.
4a. Facility Name *(If not institution, give street and number)*: 8101 Connecticut Avenue S-610
4b. City, Town, or Location of Death: Chevy Chase
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 280-20-6893
6. Sex: 1☒M 2☐F
7. Age *(In yrs. last birthday)*: 80 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Feb. 4, 1918
9. Birthplace *(State or Foreign Country)*: Ohio

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Chevy Chase
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 8101 Connecticut Avenue, #S-610
10f. Zip Code: 20815
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 5+ College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Banker
16b. Kind of Business/Industry: GOLDOME BANK
17. Father's Name *(First, Middle, Last)*: Wladyslaw Lotarski
18. Mother's Name *(First, Middle, Maiden Surname)*: Marianna Goleniewski
19a. Informant's Name/Relationship *(Type, Print)*: Anna Gerlach Lotarski Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8101 Connecticut Avenue, S-610 Chevy Chase MD 20815
20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gate Of Heaven Cemetery
Date: 11/19/98
20c. Location - City or Town, State: Silver Spring, MD
21. Signature of Funeral Service Licensee: Hugh M. [illegible]
22. Name and Address of Facility: Joseph Gawler's Sons, Inc. 5130 Wisconsin Avenue N.W., Washington, D.C. 20016

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List *only one* cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
e. CEREBRAL VASCULAR DISEASE — 6 mos

Due to (or as a consequence of):
b. HYPERTENSION

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No
26. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 6☐Other *(Specify)*
27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Lawrence McDonald MD
29c. License number: 13889 DC
29d. Date signed *(Month, Day, Year)*: 11-16-98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Lawrence McDonald, M.D. 2112 F Street, N.W.,#603, Washington, D.C. 20037

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 18 1998
32. Registrar's Signature: [illegible] G. Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

100

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 07202

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Katherine O. Lofstrand

2. Date of Death: Month November Day 13, Year 1998

3. Time of Death: 6:42 AM

4a. Facility Name (If not institution, give street and number): Washington Adventist Hospital

4b. City, Town, or Location of Death: Takoma Park

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 220-34-9096

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 86 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 9, 1912

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decadent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1610 Dale Drive

10f. Zip Code: 20910

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Library Technician

16b. Kind of Business/Industry: Federal Government

17. Father's Name (First, Middle, Last): George Olsen

18. Mother's Name (First, Middle, Maiden Surname): Bessie Mae Violette

19a. Informant's Name/Relationship (Type, Print): Anders R. Lofstrand, III/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10264 Highland School Road, Myersville, Maryland 21773

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Montgomery Crematorium, Inc. Date: November 16,1998

20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service Licensee: Michael E. Huggins M00846

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805

Physician /Medical Examiner

23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Aortic Stenosis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Spinal Stenosis

Due to (or as a consequence of):

c. Congestive Heart Failure

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Lumbar Compression Fracture

Multiple Left Rib Fracture

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

28. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year): October 20,1998

28b. Time of Injury: unknown M

28c. Injury at Work? 1☐ Yes 2☒ No

28d. Describe how injury occurred: Garage Door Closed on Her

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Home

28f. Location (Street and Number or Rural Route Number, City or Town, State): 1610 Dale Drive Silver Spring, Maryland

29a. Certifier (Check only one): 1☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD DME

29c. License number: D00428

29d. Date signed (Month, Day, Year): November 16, 1998

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Ira N. Brecher, 2101 Medical Park Drive, #304, Silver Spring, Maryland 20902-4053

State Registrar

31. Date filed (Month, Day, Year): NOV 17 1998

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37283

Physician /Medical Examiner

1. Decadant's Name (First, Middle, Last)	2. Data of Daath Month Day Yaar	3. Tima of Death
Laurence L. Liston	November 14, 1998	9:00 PM

4e Facility Neme (If not institution, give street end number)	4b. City, Town, or Location of Daath	4c. County of Death
Suburban Hospital	Bethesda	Montgomery

Funeral Director

5. Social Security Number	6. Sax	7. Age (In yrs. last birthdey)	If Under 1 Year Months / Days	If Under 24 Hrs. Hours / Min.	8. Data of Birth (Month, Day, Yaar)	9. Birthplace (State or Foraign Country)
236-14-8922	1☒ M 2☐ F	79 Yrs.			August 16, 1919	West Virginia

Usual Rasidanca of Dacedant

10a. Stata	10b. County	10c. City, Town or Location	10d. Insida City Limits
Maryland	Montgomery	Bethesda	1☐ Yas 2☒ No

10e. Street and Number	10f. Zip Coda	10g. Citizan of What Country?
6021 Walhonding Road	20816	United States

11. Marital Status	12. Was Dacadant Evar in U.S. Armad Forces?	13. Was Dacedant of Hispenic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.)	14. Race - American Indian, Black, Whita, atc.
1☐ Navar Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☒ Yas 2☐ No If Yas, Giva Yaar or Datas: World War II	1☐ Yas 2☒ No *Specify:*	*Specify:* White

15. Decadant's Education (Specify only highast grada compliatad)		16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	Collega (1-4or 5+)		
	4	Transportation Economist	United States Government

17. Fathar's Name (First, Middle, Last)	18. Mothar's Nama (First, Middle, Maidan Sumama)
John A. Liston	Virginia Sterling

19a. Informant's Name/Relationship (Typa, Print)	19b. Mailing Address (Street and Numbar or Rural Routa Numbar, City or Town, Stata, Zip Coda)
Ruth D. Liston / wife	6021 Walhonding Road, Bethesda, Maryland 20816

20a. Mathod of Disposition	20b. Placa of Disposition (Nama of cemetery, crematory or othar placa)	Data	20c. Location - City or Town, Stata
1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donetion 5☐ Othar (Specify)	Parklawn Memorial Park	November 18, 1998	Rockville, Maryland

21. Signatura of Funaral Sarvica Licansaa	22. Nama and Address of Facility
▶ Barbara J. McMullen Lawrence M00831	Robert A. Pumphrey Funeral Home / Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Part1. Entar tha diseasa, or complications that caused the deeth. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only one cause on each line.

		Approximate Intarval Between Onsat and Daath
Immadiate Ceusa (Final disaasa or condition resulting in daath)	a. Pulmonary embolism	2 weeks.
	Dua to (or as a consequenca of):	
Sequantially list conditions, if any, laading to immadiate causa. Entar Underlying Causa (Disaasa or injury that initiated avants rasulting in death) Last	b.	
	Dua to (or as a consequanca of):	
	c.	
	Dua to (or as a consequanca of):	
	d.	

Part II. **Othar significant conditions** contributing to death but not rasulting in tha undarlying causa given in Part I.

Gastrointestinal bleed, hematuria
Severe coronary artery disease,
Congestive heart failure

23b. Did tobacco usa contributa to the cause of death?	24a. Was an autopsy parformad?	24b. Were autopsy findings availabla prior to completion of causa of death?
1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown	1☐ Yas 2☒ No	1☐ Yas 2☐ No

25. Was casa raferrad to madical examiner?	26. Placa of Death (Check only ona)	
1☒ Yas 2☐ No	Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA	Othar: 4☐ Nursing Homa 5☐ Residanca 6☐ Othar (Specify)

27. Mannar of Death	28a. Data of Injury (Month, Day Yaar)	28b. Tima of Injury	28c. Injury at Work?	28d. Dascriba how injury occurred
1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding Invastigation 6☐ Could not be datarmined		M	1☐ Yas 2☐ No	
	28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify)			28f. Location (Streat and Numbar or Rural Routa Numbar, City or Town, Stata)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, end dua to the ceuse(s) end mennar es steted.
2☐ **Medical Examiner:** On the basis of axamination and/or Investigation, in my opinion, daath occurred at tha tima, data and place, end dua to tha causa(s) and mannar stated.

29b. Signatura end title of certifier	29c. Licansa number	29d. Date signed (Month, Day, Year)
▶ [signature] MD	D42518	November 15, 1998

30. Nema end addrass of person who completed cause of death (Item 23e) (Type, Print)
GAIL CHAIKEN, MD, 11119 Rockville Pike #316, Rockville MD 20852

State Registrar

31. Data filad (Month, Day, Yaar)	32. Registrar's Signatura
NOV 17 1998	[signature]

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37204

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Virginia L. Lippy

2. Date of Death — Month: November; Day: 14; Year: 1998

3. Time of Death: 12:20 PM

4a. Facility Name *(If not institution, give street and number)*: Bedford Court Nursing Home

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 066-01-9843

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 86 Yrs.

If Under 1 Year — Months: ; Days: ; If Under 24 Hrs. — Hours: ; Min.:

8. Date of Birth *(Month, Day, Year)*: Nov. 25, 1911

9. Birthplace *(State or Foreign Country)*: Missouri

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: Montgomery

10c. City, Town or Location: Darnestown

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 15105 Grey Pebble Drive

10f. Zip Code: 20874

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Dance Instructor

16b. Kind of Business/Industry: Dance

17. Father's Name *(First, Middle, Last)*: Frank Volmer

18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Brookshire

19a. Informant's Name/Relationship *(Type, Print)*: Donna Miller (niece)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 15105 Grey Pebble Drive, Darnestown, MD 20874

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Parklawn Memorial Park

Date: 11/17/98

20c. Location - City or Town, State: Rockville, MD

21. Signature of Funeral Service Licensee: Francis J. Collins

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Parkinson's Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Ellen Pinholt MD

29c. License number: D51015

29d. Data signed *(Month, Day, Year)*: November 16, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ellen Pinholt, M.D., 5530 Wisconsin Avenue, Chevy Chase, MD 20815

State Registrar

31. Data filed *(Month, Day, Year)*: NOV 17 1998

32. Registrar's Signature: Geneva G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37205

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Thomas Y. Lee

2. Date of Death Month / Day / Year: NOVEMBER 13, 1998

3. Time of Death: 09:47 AM

4e. Facility Name *(If not institution, give street and number)*: 8227 NEW HAMPSHIRE AVENUE

4b. City, Town, or Location of Death: HYATTSVILLE

4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 577-48-1282

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 71 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Sept 10, 1927

9. Birthplace *(State or Foreign Country)*: China

Usual Residence of Decedent

10e. State: Maryland

10b. County: Prince Georges

10c. City, Town or Location: Hyattsville

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 8227 New Hampshire Ave

10f. Zip Code: 20783

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Asian

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12 / College (1-4or 5+):

16e. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Mechanic

16b. Kind of Business/Industry: Automotive

17. Father's Name *(First, Middle, Last)*: Kenneth W. Lee

18. Mother's Name *(First, Middle, Maiden Surname)*: Tse May

19e. Informant's Name/Relationship *(Type, Print)*: Hang Lee/Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8227 New Hampshire Ave, Hyattsville, MD 20783

20e. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: George Washington Cem.

Date: Nov 20

20c. Location - City or Town, State: Adelphi, MD

21. Signature of Funeral Service Licensee: ▶ Adam J. Donnell

22. Name and Address of Facility: Hines-Rinaldi Funeral Home 11800 New Hampshire Ave, Silver Spring, MD 20904

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. HANGING

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: DEPRESSION

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [X] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day, Year)*: 11-13-98

28b. Time of Injury: 09:47 AM

28c. Injury at Work? 1 [ ] Yes 2 [X] No

28d. Describe how injury occurred: SUBJECT HANGED SELF

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: HOME

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: HYATTSVILLE 8227 NEW HAMPSHIRE AVE, MARYLAND

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] MD DME

29c. License number: D 33954

29d. Date signed *(Month, Day, Year)*: NOVEMBER 13, 1998

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): MARIO E. GOLLE JR MD 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 16 1998

32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37206

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): T'Aira Joy Lane

2. Data of Death Month Dey Year: Nov. 14, 1998

3. Time of Death: 6:26 AM

4a. Facility Name (If not Institution, giva street and numbar): Holy Cross Hospital

4b. City, Town, or Location of Deeth: Silver Spring

4c. County of Death: MONTGOMERY

Funeral Director

5. Sociel Security Number: N/A

6. Sex: 1☐ M 2☒ F

7. Aga (In yrs. last birthdey) Yrs.: If Under 1 Yaar Months: Deys: 4; If Under 24 Hrs. Hours: Min.:

8. Date of Birth (Month, Dey, Yeer): Nov.10, 1998

9. Birthpleca (Stete or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Montgomery

10c. City, Town or Location: Germantown

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 19949 SToney Point Way

10f. Zip Code: 20876

10g. Citizen of Whet Country?: U.S.A.

11. Maritel Status: 1☒ Nevar Marriad 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Maxican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Raca - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grede completed) Elementary/Secondery (0-12): N/A College (1-4or 5+):

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): N/A

16b. Kind of Business/Industry: N/A

17. Fether's Name (First, Middla, Last): Terry Lane

18. Mother's Nama (First, Middle, Maidan Surname): Brandi Bledsoe

19a. Informent's Neme/Reletionship (Type, Print): Brandi Bledsoe (Mother)

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 19949 Stoney Point Way, Germantown, MD 20876

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other piece): Gate of Heaven Cem.

Date: 11/18/98

20c. Location - Clty or Town, State: MD Silver Spring,

21. Signature of Funerel Service Licensea: George R. Snowden

22. Name end Address of Facility: SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850

Physician /Medical Examiner

23a. Part1. Enter the disaase, or complications that caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Deeth

Immadiate Cause (Finel disease or condition resulting in death)

e. pulmonary hemorrhage

Due to (or es a consequenca of):

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Disease or Injury thet initieted events resulting in death) Last

b. prematurity

Due to (or es e consequence of):

c. Significant growth retardation

Due to (or es e conseguence of):

d.

Part II. **Other significant conditiona** contributing to death but not resulting in the underlying cause given in Pert I.

23b. **Did tobacco use contribute to the cauee of death?** 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performad? 1☐ Yes 2☑ No

24b. Were eutopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☑ No

26. Plece of Death (Check only one) Hospital: 1☑ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Othar (Specify)

27. Manner of Deeth: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Physicien**: To the best of my knowledge, death occurred et the time, date end plece, and due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner**: On the besis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the cause(s) end manner stated.

29b. Signature end title of certifier: C. Gannon, MD

29c. License number: D0054008

29d. Date signed (Month, Dey, Yeer): 11/14/98

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print): Catherine Gannon, MD NICU Holy Cross Hospital, 1500 Forest Glen Rd. Silver Spring MD 20910

State Registrar

31. Date filed (Month, Day, Yaer): NOV 17 1998

32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37287

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARCIA A LYNCH
2. Date of Death: Month November Day 9 Year 1998
3. Time of Death: 1:37 PM
4a. Facility Name (If not institution, give street end number): Johns Hopkins Hospital
4b. City, Town, or Location of Death: Baltimore CITY
4c. County of Death: None

Funeral Director

5. Social Security Number: 578-44-6016
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 64 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan 25, 1934
9. Birthplace (State or Foreign Country): Oregon

Usual Residence of Decedent

10a. State: Deleware
10b. County: Sussex
10c. City, Town or Location: Selbyville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 17 Ruth Street
10f. Zip Code: 19975
10g. Citizen of Whet Country?: United States

11. Merital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Rece - American Indian, Bleck, White, etc. Specify: White
15. Decedent's Eduction (Specify only highest grade completed): Elementary/Secondery (0-12) / College (1-4or 5+): 2
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Mortgage Banker
16b. Kind of Business/Industry: Banking
17. Fether's Name (First, Middle, Last): O. Henry Alexander
18. Mother's Neme (First, Middle, Maiden Surneme): Muriel Walther
19a. Informant's Name/Reletionship (Type, Print): Sandra Carter/Sister
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 13102 Orleans Street Woodbridge, VA 22192
20a. Method of Disposition: 1☐ Buriel 2☒ Cremetion 3☐ Removal from Stete 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Metro Crematory
Dete: 11-10-98
20c. Location - City or Town, Stete: Catonsville, MD
21. Signature of Funeral Service Licensee: Shawn A Collins-Witzke
22. Neme end Address of Facility: Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043

Physician /Medical Examiner

23e. Part1. Enter the diseese, or complicetions that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death)
a. cardiac tamponade — minutes

Due to (or as e consequence of):
b. sepsis — hours

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last

Due to (or as e consequence of):
c. Allogeneic bone marrow transplant — 5 days

Due to (or es e consequence of):
d. Acute mydogenous leukimia, chronic lymphocytic leukemia — 3 months

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. Did tobacco use contribute to the ceuse of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24e. Wes en autopsy performed? 1☑ Yes 2☐ No

24b. Were autopsy findings aveilable prior to completion of cause of death? 1☑ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Piece of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Deeth: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Phyeician:** To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end menner as stated. 2☐ **Medical Exeminer:** On the basis of examination end/or investigetion, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) end manner stated.

29b. Signeture end title of certifier: M.D.
29c. License number: RES-000
29d. Dete signed (Month, Dey, Year): November 9, 1998

30. Name end eddress of person who completed ceuse of death (Item 23e) (Type, Print): S. Arai Johns Hopkins Hospital 550 N Broadway Balt MD 21205

State Registrar

31. Date filed (Month, Day, Year): NOV 12 1998
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

Medical Certification: To Be Completed by Physician/Medical Examiner

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37208

Physician /Medical Examiner

1. Decedant's Nama *(First, Middle, Last)*: August Lukrafka

2. Dete of Death — Month: Nov; Day: 14; Year: 1998

3. Time of Deeth: 1:00am

4a. Facility Nama *(If not institution, giva street and number)*: 2610 Sara Beth Court

4b. City, Town, or Location of Death: Ellicott City

4c. County of Death: Howard

Funeral Director

5. Social Security Number: 084-01-5559

6. Sax: 1☒M 2☐F

7. Age *(In yrs. last birthday)*: 93 Yrs.

If Undar 1 Yaar — Months: ; Days:

If Under 24 Hrs. — Hours: ; Min.:

8. Data of Birth *(Month, Day, Yaar)*: Sept 19, 1905

9. Birthplace *(Stata or Foraign Country)*: Germany

Usual Residence of Dacedant

10a. Stata: Maryland

10b. County: Howard

10c. City, Town or Location: Ellicott City

10d. Insida City Limits: 1☐Yas 2☒No

10e. Street and Number: 2610 Sara Beth Court

10f. Zip Coda: 21042

10g. Citizan of What Country?: United States

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Wes Decedent Ever in U.S. Armed Forcas? 1☒Yas 2☐No If Yas, Giva Yaar or Datas: 1/43-9/43

13. Was Decadant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxicen, Puarto Rican, atc.) 1☐Yas 2☒No *Specify:*

14. Rece - Amaricen Indian, Black, Whita, atc. *Specify:* White

15. Decedant's Education *(Specify only highast grada complatad)*: Elementery/Secondary (0-12): 9; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Giva kind of work done during most of working lifa. DO NOT usa retired)*: Painter & Wall Paper Hanger

16b. Kind of Business/Industry: Construction

17. Fether's Name *(First, Middle, Last)*: August Lukrafka

18. Mothar's Nema *(First, Middla, Maidan Sumama)*: Augusta Untermann

19a. Informant's Name/Relationship *(Type, Print)*: Linda M. Ford/Niece

19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 2610 Sara Beth Court Ellicott City, MD 21042

20a. Mathod of Disposition: 1☐Burial 2☒Cremetion 3☐Ramoval from Stata 4☐Donation 5☐Othar *(Specify)*

20b. Placa of Disposition *(Nama of camatary, cramatory or othar pleca)*: Metro Crematory

Data: 11-14-98

20c. Location - City or Town, Stata: Catonsville, MD

21. Signatura of Funaral Sarvice Licensaa: Sharon A Collins - Witzke

22. Nama and Address of Facility: Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043

Physician /Medical Examiner

23a. Part1. Enter the diseesa, or complicetions that ceused the death. Do not antar the mode of dying, such es cardiac or respiratory arrast, shock, or heart failure. List only one ceuse on each line.

Approximata Intarval Betwaen Onset and Death

Immediata Causa (Final disaasa or condition resulting in death)

e. COLON CANCER — Unknown

Dua to (or as a consequence of):

Sequantially list conditions, if any, laading to immadiata ceusa. Entar Underlying Ceuse (Disaasa or Injury that initieted evants resulting in daath) Last

b. ANEMIA — months

Due to (or as a consaquance of):

c. COLOSTOMY — Months

Due to (or es e consequance of):

d.

Part II. **Othar significant conditions** contributing to daath but not resulting in tha underlying ceusa givan in Pert f.

ARTERIOSCLEROTIC CARDIO VASCULAR DISEASE

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yas 2☒No

24b. Were eutopsy findings availabla prior to completion of ceusa of deeth? 1☐Yas 2☐No

25. Was cesa rafarrad to medical examinar? 1☐Yas 2☒No

26. Piece of Daath *(Chack only one)*: Hospitel: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Homa 5☒Rasidance 6☐Othar *(Specify)*

27. Manner of Death: 1☒Naturel 2☐Accident 3☐Suicide 4☐Homicida 5☐Panding invastigation 6☐Could not be datarmined

28a. Date of Injury *(Month, Day Year)*

28b. Tima of Injury

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28a. Place of Injury - At homa, farm, street, factory, offica building, atc. *(Specify)*

28f. Location *(Streat and Number or Rural Route Number, City or Town, Stata)*

29a. Cartifier *(Check only one)*: ☒ **Certifying Physician:** To tha best of my knowledge, daath occurred at tha tima, data end place, and dua to tha causa(s) and manner as stated. ☐ **Madical Examiner:** On tha basis of axamination end/or invastigation, in my opinion, daath occurred at tha tima, data and place, end dua to tha causa(s) and mannar statad.

29b. Signature and titla of certifier: John E Seidel MD

29c. License number: MD 25210

29d. Data signed *(Month, Day, Yaar)*: November 14, 1998

30. Nama and address of parson who complated cause of daath (Item 23a) (Type, Print): JERRY STOKES MD 3440 ELLICOTT CENTER DR. ELLICOTT CITY, MD

State Registrar

31. Data filed *(Month, Day, Yaar)*: NOV 17 1998

32. Registrer's Signatura: Geneva G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours aftar death with the Maryland Department of Haalth and Mantal Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attanding Physician: Tha law requires that tha daath cartificata be executed within 24 hours after daath.
To the Funeral Director: After this cartificate has baan signed by the attending physician and completely filled in by the funaral director, paga 2 should be datached for usa as the burial-transit

5

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37289

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James Lohman

2. Date of Death: Month Nov. Day 23 Year 1998

3. Time of Death: 2:50pm

4a. Facility Name (If not institution, give street and number): Southern Maryland Hospital

4b. City, Town, or Location of Death: Clinton

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 579 40 7931

6. Sex: XX 1 M 2 F

7. Age (In yrs. last birthday): 66 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept 27, 1932

9. Birthplace (State or Foreign Country): Washington DC

Usual Residence of Decedent

10a. State: MD

10b. County: P.G.

10c. City, Town or Location: Temple Hills

10d. Inside City Limits: 1 Yes 2 XX No

10e. Street and Number: 2836 Iverson Street

10f. Zip Code: 20748

10g. Citizen of What Country?: United States

11. Marital Status: 1 Never Married 2 XX Married 3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 X No Specify:

14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementery/Secondary (0-12): 9th

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Print Shop Manager

16b. Kind of Business/Industry: Heckengos

17. Father's Name (First, Middle, Lest): Howell Fenton

18. Mother's Name (First, Middle, Maiden Surname): Lola W. Layfield

19a. Informant's Neme/Reletionship (Type, Print): Doris Marie Lohman (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2836 Iverson Street, Temple Hills, Md 20748

20e. Method of Disposition: 1 X Burial 2 Cremation 3 Removel from State 4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Fort Lincoln Cemetery

Date: Nov 27,1998

20c. Location - City or Town, Stete: Brentwood, Maryland

21. Signature of Funeral Service Licensee: ▶ Sth E. Sith

22. Name end Address of Fecility: Lee Funeral Home,Inc. 6633 Old Alexandria Ferry Road, Clinton,Md 20735

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heert teilure. List only one cause on eech line.

Approximate Interve1 Between Onset end Death

Immediate Ceuse (Final diseese or condition resulting in death): e. vericel bleed — 48hrs

Due to (or as e consequence of): b. cerrhes cirrhosis — 2 years

Sequentiellty list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in death) Last

Due to (or es e consequence of): c. excessive alcohol intake — 10 years

Due to (or as e consequence of): d.

Pert tt. **Other significant conditions** contributing to death but nof resulting in the underlying cause given in Pert I.

23b. Did tobacco use contributa to the cause of death? 1 Yes 2 X No 3 Probably 4 Unknown

24a. Wes en eutopsy performed? 1 Yes 2 X No

24b. Were eutopsy findings aveilable prior fo completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 X No

26. Place of Death (Check only one): Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Deeth: 1 X Neturel 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28e. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1 Yes 2 No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) end manner es stated. 2 **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) end menner steted.

29b. Signeture and title of certifier: ▶ MD Thomas Gage, MD

29c. License number: D 21607

29d. Date signed (Month, Day, Year): 11/24/98

30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print): Thomas Gage, M.D. 12070 Old Line Center, Waldorf, 20602

State Registrar

31. Dete filed (Month, Day, Year): NOV 25 1998

32. Registrar's Signefure: ▶ Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

25+1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37290

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Rose Lloyd
2. Date of Death: Month Nov. Day 17, Year 1998
3. Time of Death: 10:05 P.M.
4a. Facility Name *(If not institution, give street and number)*: Larkin Chase Nursing & Restorative Center
4b. City, Town, or Location of Death: Bowie
4c. County of Death: Prince George's Co.

Funeral Director

5. Social Security Number: 178-01-2198
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 83 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: March 19 1915
9. Birthplace *(State or Foreign Country)*: Mt. Carmel PA

Usual Residence of Decedent

10a. State: Maryland
10b. County: Calvert
10c. City, Town or Location: Dunkirk
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 12441 Uncle Charlie's Spur
10f. Zip Code: 20754
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11; College (1-4or 5+):
18a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Waitress
16b. Kind of Business/Industry: Restaurant

17. Father's Name *(First, Middle, Last)*: Joseph Kowalczyk
18. Mother's Name *(First, Middle, Maiden Surname)*: Anna Mazur

19a. Informant's Name/Relationship *(Type, Print)*: James R. Lloyd, Jr. (son)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 12441 Uncle Charlie's Spur, Dunkirk, MD 20754

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Resurrection Cemetery
Date: Nov 20, 98
20c. Location - City or Town, State: Clinton, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: 8125 So. Md. Blvd. Owings, MD — Lee Funeral Home Calvert, PA

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Atherosclerotic Cerebrovascular disease — years

Due to (or as a consequence of):
b. Carcinoma of colon — 1 yr.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] Rakesh Arora, MD
29c. License number: D20108
29d. Data signed *(Month, Day, Year)*: November 18 98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Rakesh Arora, MD 14300 Gallant Fox Ln. Bowie, MD

State Registrar

31. Data filed *(Month, Day, Year)*: NOV 24 1998
32. Registrar's Signature: [signature] B. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 07291

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: James Vickers Legg

2. Data of Death Month / Day / Yaar: October 21, 1998

3. Tima of Death: 11:30a.m.

4a. Facility Nama *(If not institution, giva street and numbar)*: 257 Duke of Kent Street

4b. City, Town, or Locatian of Deith: Chestertown

4c. County of Death: Kent

Funeral Director

5. Social Sacurity Number: 173-26-1859

6. Sax: 1☒ M 2☐ F

7. Aga *(In yrs. last birthday)*: 65 Yrs. — If Under 1 Yaar: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Yaar)*: April 25, 1933

9. Birthplace *(Stata or Foraign Country)*: Maryland

Usual Rasidanca of Dacadant

10a. Stata: Maryland

10b. County: Kent

10c. City, Town or Location: Chestertown

10d. Insida City Limits: 1☒ Yas 2☐ No

10e. Street and Numbar: 257 Duke of Kent Street

10f. Zip Coda: 21620

10g. Citizan of What Country?: USA

11. Marital Status: 1☒ Navar Marriad 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decadant Evar in U.S. Armad Forcas? 1☒ Yas 2☐ No — If Yas, Giva Yaar or Datas:

13. Was Decadant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.): 1☐ Yas 2☒ No *Specify:*

14. Race - Amaricen Indian, Black, Whita, atc. *Specify:* White

15. Decadant's Educetion *(Specify only highast grada complatad)*: Elamantary/Secondary (0-12): 12 — Collaga (1-4or 5+):

16a. Dacadant's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa ratirad)*: Accounts Receviable

16b. Kind of BusInass/Industry: Chemical Plant

17. Fathar's Nama *(First, Middla, Last)*: Arthur Kaslin Legg

18. Mothar's Nama *(First, Middla, Maidan Surnama)*: Violet Evana LeCates

19a. Informant's Name/Ralationship *(Type, Print)*: Peggy Schauber

19b. Mailing Address *(Street and Numbar or Rural Routa Numbar, City or Town, Stata, Zip Coda)*: 257 Duke of Kent Street, Chestertown, MD 21620

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Placa of Disposition *(Nama of cematary, cramatory or othar placa)*: Chester Cemetery

Data: 10/24/98

20c. Location - City or Town, Stata: Chestertown, MD

21. Signature of Funeral Service Licensee: Kirk A. Helfebein

22. Nama and Addrass of Facility: Fellows, Helfebein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that causad tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only one causa on aach lina. — Approximata Intarval Betwaan Onsat and Death

Immediata Causa (Final disaasa or condition resulting in daath):

a. CARDIOpulmonary Arrest

Dua to (or as a consequence of):

Saquantially list conditions, if any, laading to immadiata ceusa. Entar Underlying Causa (Disaasa or Injury that initiated avants rasulting in daath) Last:

b. Metastatic Pancreatic Cancer from to Bone

Dua to (or as a consequanca of):

c.

Dua to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.: History of Coronary Artery Disease and Bypass Graft x 3 Vessels 1/5/89, Hypertension

23b. Did tobacco usa contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy parformad? 1☐ Yas 2☒ No

24b. Wara autopsy findings availabla prior to complation of ceusa of daath? 1☐ Yas 2☐ No

25. Was cesa rafarred to madicel examinar? 1☐ Yas 2☑ No

26. Placa of Daath *(Chack only ona)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA — Othar: 4☐ Nursing Homa 5☑ Rasidance 6☐ Othar *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accidant 3☐ Sulcida 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be datarmined

28a. Data of Injury *(Month, Day Yaar)*: None

28b. Tima of Injury: M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how Injury occurred

28a. Place of Injury - At homa, farm, straat, factory, office building, atc. *(Specify)*: None

28f. Location *(Straat and Numbar or Rural Routa Numbar, City or Town, Stata)*

29a. Cartifiar *(Check only one)*: 1☑ **Cartifying Physician:** To tha best of my knowladga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and placa, and dua to tha ceusa(s) and mannar stated.

29b. Signatura and titla of cartifiar:

29c. Licansa number: D23589

29d. Data signad *(Month, Day, Yaar)*: 10/23/98

30. Nama and addrass of parson who completed ceusa of daath (Itam 23a) (Type, Print): John C. Arrabal, Jr. MD, 948 Washington Ave., Chestertown, MD 21620

State Registrar

31. Data filed *(Month, Day, Yaar)*: NOV 30 1998

32. Registrar's Signatura: D. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEMS: #27,28A-F PER PHY G767 1-20-99 WR. **Certificate of Death**

Reg. No. 98 37292

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): ANNA MAE MORTON

2. Date of Deeth: Month NOVEMBER Day 25 Yaar 1998

3. Time of Death: 0001

4a Facility Neme (If not institution, give street end number): PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

Funeral Director

5. Sociel Security Number: 136-12-4426

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 82 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Year): 4 - 24- 16

9. Birthplace (State or Foreign Country): New Jersey

Usuel Residence of Decedent

10a. Stete: Md.

10b. County: Worcester

10c. City, Town or Location: Snow Hill

10d. Insida City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 8247 Public Landing Road

10f. Zip Code: 21863

10g. Citizen of Whet Country?: U.S.A.

11. Maritel Status: 1☐ Naver Marriad 2☐ Marriad 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Rece - American Indian, Bleck, White, etc. Specify: white

15. Decedent's Educetion (Spacify only highest greda completed): Elementary/Secondary (0-12): 11 College (1-4or 5+): 4

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): homemaker

16b. Kind of Business/Industry: own home

17. Fether's Neme (First, Middle, Last): William Woodland

18. Mother's Nama (First, Middle, Maiden Sumema): Adah Woolston (Woodland)

19a. Informent's Name/Reletionship (Type, Print): Steven P. Clark (son)

19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code): 7041 Flint Hill Rd., Owings, Md.20736

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)

20b. Placa of Disposition (Neme of cemetery, cremetory or other piece): Salisbury Crematory

Date: 11/25/98

20c. Location - City or Town, Stete: Salisbury, Md.

21. Signature of Funeral Service Licensee: Patricia L Dennis

22. Name end Address of Facility: P.O. Box 87 Dennis Funeral Home, Snow Hill, Md. 21863

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician Medical Examiner

23a. Pert1. Enter the diseese, or complications that ceused the death. Do not enter tha mode of dying, such es cerdiec or respiratory errest, shock, or heart failure. List only one cause on eech line.

Approximete Interval Between Onset and Deeth

Immediete Ceuse (Final diseese or condition resulting in death): e. Multiple trauma c rupture clan y AV as well

Due to (or es a consequence of): b. ruptured spleen rib fractures, cardiac pulm contusion

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

Due to (or es a consequence of): c. hypotension secondary 2° #1

Due to (or es a consequence of): d. Asystole 2° above

CERTIFICATION ACCEPTED BY MEDICAL EXAMINER

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause givan in Part I: ATN

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical exeminer? 1☐ Yes 2☒ No

26. Piece of Death (Check only one): Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Deeth: 1☒ Natural 2☒ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year): 11-22-98

28b. Time of Injury: 1430 M

28c. Injury at Work? 1☐ Yes 2☒ No

28d. Describe how injury occurred: PASSENGER IN VEHICLE ROLLED OVER

28e. Piece of injury - At home, farm, street, factory, office building, etc. (Specify): ROAD

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete): RT. 12. NR ST. LUKE RD. SNOW HILL MD.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pega 2 should be detached for use es the burial-transit

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end manner es steted. 2☐ **Medical Examiner:** On the besis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the ceuse(s) and manner stated.

29b. Signeture end title of certifier:

29c. Licensa number: D33796

29d. Date signed (Month, Day, Year): 11/25/98

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): DAVID WALKER 560 RIVERSIDE DR. SALISBURY, MD. 21801

State Registrar

31. Date filed (Month, Day, Year): NOV 25 1998

32. Registrer's Signeture: B. Franks

DHMH 16 Rev 6/95

ANNA M. MORTON

10

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37293

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WORTH MULLINAX
2. Date of Death (Month, Day, Year): NOVEMBER 11, 1998
3. Time of Death: 08:45 PM
4a. Facility Name (If not institution, give street and number): PRINCE GEORGES HOSPITAL CENTER
4b. City, Town, or Location of Death: CHEVERLY
4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 577-16-1402
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 88 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MARCH 16, 1910
9. Birthplace (State or Foreign Country): S. CAROLINA

Usual Residence of Decedent

10a. State: MD.
10b. County: PRINCE GEORGES
10c. City, Town or Location: RIVERDALE
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 4900 RIVERDALE RD.
10f. Zip Code: 20737
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 7; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): GLAZER
16b. Kind of Business/Industry: PRIVATE

17. Father's Name (First, Middle, Last): John Mullinax
18. Mother's Name (First, Middle, Maiden Surname): Anna Belle Hound

19a. Informant's Name/Relationship (Type, Print): MICHELLE RESHENBERG/ GRAND DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): SAME AS ITEM #10

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MARYLAND VETERANS CEMETERY
Date: 11/23/98
20c. Location - City or Town, State: CHELTENHAM, MD.

21. Signature of Funeral Service Licensee: W. W. Chambers MOOO91
22. Name and Address of Facility: CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737

DMW

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS

CANCER OF PROSTATE

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of ceuse of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner**: On the basis of examination end/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D 33954
29d. Date signed (Month, Day, Year): NOVEMBER 13, 1995

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARIO F. GOLIE JR MD 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785

State Registrar

31. Date filed (Month, Day, Year): NOV 17 1998
32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1+1

98-6587-031
B.K.S

MARIA MOLINA
ITEMS: #28F PER MEO G766 12-14-98 WR.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

98 37294
Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
Marie	E.	Molina	NOV. 12, 1998	2152 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
SUBURBAN HOSPITAL	BETHESDA	MONTGOMERY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-23-9719	1☐ M 2☒ F	58 Yrs.			June 10, 1940	El Salvador

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Wheaton	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3104 Henderson Ave.	20902	El Salvador

11. Maritel Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - Americen Indien, Bleck, White, etc.
1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Yeer or Detes:	1☒ Yes 2☐ No Specify: El Salvadorian	Specify: Hispanic

15. Decedent's Eduction (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Cafeteia attendant	4H International Center

17. Fether's Name (First, Middle, Last)		18. Mother's Neme (First, Middle, Maidan Sumame)	
Thomas	Reyes	Desederia	Molina

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Streat and Number or Rural Routa Number, City or Town, State, Zip Code)
George A. Molina/ Son	3104 Henderson Ave., Wheaton, Md. 20902

20a. Method of Disposition	20b. Place of Disposition (Nama of cemetary, cramatory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donation 5☐ Other (Specify)	Gate of Heaven Cemetery	11/14/98	Silver Spring, Md.

21. Signature of Funeral Service Licensee: Wayne T. Bushy

22. Name and Address of Facility: Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, Maryland 20904

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one ceuse on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Multiple Injuries	
	Due to (or es e consequence of):	
Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury that Initieted events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or es a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was en autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒ Yes 2☐ No	1☒ Yes 2☐ No

25. Was cese referred to medical examiner?	26. Piece of Deeth (Check only one)	
☒ Yes 2☐ No	Hospitel: 1☐ Inpatient 2☒ ER/Outpetient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Spacify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined	11-12-98	1936 hr M	1☐ Yes 2☒ No	pedestrian struck by car

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Spacify)	28f. Location (Straat end Number or Rural Routa Number, City or Town, State)
STREET	Thornapple and Connecticut Ave Montgomery Co, Md

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end piece, end due to the ceuse(s) end manner as steted. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Dennis J. Chute, MD	O.C.M.E	NOV. 13, 1998

30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print): Dennis J. Chute, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Yaar)	32. Registrar's Signature
NOV 18 1998	G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

6

SEE OVER

11/18 - Noticed 28e was blank; called Dr Chute's office
I was told to file certificate. He would send
Additional statement to Baltimore

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37295

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Glenn Ellis Milligan

2. Date of Death Month / Day / Year: NOV. 13 1998

3. Time of Death: 0615

4e. Facility Name *(If not institution, give street and number)*: Suburban Hospital

4b. City, Town, or Location of Death: Bethesda

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 513-01-0069

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 79 Yrs.

If Under 1 Yeer: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Dey, Year)*: November 12, 1919

9. Birthplace *(State or Foreign Country)*: Kansas

Usuel Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Bethesda

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street end Number: 5208 Elsmere Avenue

10f. Zip Code: 20814

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Ricen, etc.): 1 [ ] Yes 2 [X] No *Specify:*

14. Race - Americen Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grede completed)*: Elementery/Secondery (0-12) / College (1-4or 5+): 5+

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: School Psychologist

16b. Kind of Business/Industry: Education

17. Father's Neme *(First, Middle, Last)*: Ellis Milligan

18. Mother's Neme *(First, Middle, Maiden Surneme)*: Claire Krete

19a. Informent's Name/Relationship *(Type, Print)*: Janice B. Milligan/Wife

19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 5208 Elsmere Avenue, Bethesda, Maryland 20814

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Neme of cemetery, crematory or other place)*: Montgomery Crematorium, Inc. Date: November 14, 1998

20c. Locetion - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service Licensee: Michael Hagan M00846

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ANOXIC ENCEPHALOPATHY — 3 DAYS

Due to (or as e consequence of):
b. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE — YEARS

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in death) Last

Due to (or es e consequence of):
c. CHRONIC OBSTRUCTIVE PULMONARY DISEASE — YEARS

Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [ ] No

24b. Were autopsy findings avellable prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical exeminer? 1 [ ] Yes 2 [ ] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [ ] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28e. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and placa, and due to the ceuse(s) and manner as steted. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and menner stated.

29b. Signature end title of certifier: Peter G. Hamm MD

29c. License number: D32033

29d. Date signed *(Month, Dey, Year)*: 11/14/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PETER G. HAMM MD 5454 WISC AVE CHEVY CHASE MD 20815

State Registrar

31. Date filed *(Month, Dey, Yeer)*: NOV 16 1998

32. Registrar's Signature: G. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37296

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month / Day / Year	3. Time of Death
Diane	Miller	November 17, 1998	1:45 P.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
20403 Shadow Oak Court	Gaithersburg	Montgomery County

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
350-58-0371	1☐ M 2☒ F	39 Yrs.			May 19, 1959	Aurora Illinois

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Gaithersburg	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
20403 Shadow Oak Court	20870	United States of America

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	5+	Certified Financial Planner	Finance

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Ronald Miller	Ardys Bernson

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Daniel Armand/ Husband	20403 Shadow Oak Court, Gaithersburg, Maryland

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Cemetery Saint Pauls Lutheran	November 23, 1998	Montgomery, Illinois

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Howard A Causey	Dieterle Memorial Home 1120 South Broadway, Aurora, Illinois 60507

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Metastatic Lung Cancer	9 Months
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	D33293	11/18/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Frederick Pearson Smith, M.D. 5401 Western Avenue, N.W., Washington, D.C.

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 19 1998	G. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37297

Physician /Medical Examiner

1. Decedent's Nama *(First, Middle, Last)*: CHRISTINE A. MIKEL
2. Data of Death Month / Day / Yaar: NOVEMBER 13, 1998
3. Tima of Death: 10:20 AM
4a Facility Nama *(If not institution, give street and number)*: SHADY GROVE ADVENTIST NURSING
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 236-38-4718
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 76 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: MAY 5, 1922
9. Birthplace *(State or Foraign Country)*: KENTUCKY

Usual Residence of Decedent

10a. Stata: MARYLAND
10b. County: MONTGOMERY
10c. City, Town or Location: ROCKVILLE
10d. Insida City Limits: 1☒ Yas 2☐ No
10e. Street and Number: 11709 ASHLEY DRIVE
10f. Zip Code: 20852
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yas 2☒ No If Yes, Giva Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, atc.): 1☐ Yes 2☒ No *Specify:*
14. Raca - American Indian, Black, Whita, atc. *Specify:* WHITE
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Giva kind of work done during most of working life. DO NOT use retired)*: DIETICIAN
16b. Kind of Businass/Industry: HOSPITAL
17. Father's Nama *(First, Middle, Last)*: JAMES HENRY MIKEL
18. Mother's Nama *(First, Middle, Maiden Surname)*: VATES HODGE
19a. Informant's Name/Ratationship *(Type, Print)*: MARY F. BONDS (SISTER)
19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 11709 ASHLEY DRIVE ROCKVILLE,MARYLAND 20852
20a. Mathod of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stata 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetary, crematory or other place)*: SUNSET MEMORIAL PARK
Data: 11/15/98
20c. Location - City or Town, Stata: BECKLEY,WEST VIRGINIA
21. Signature of Funeral Service Licensee: [signature]
22. Nama and Address of Facility: FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD.,W.,SILVER SPRING,MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. — Approximata Intarval Batween Onsat and Death

Immediata Cause (Final disease or condition rasulting in death): a. SUBDURAL HEMATOMA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. CARDIAC ARRHYTHMIA
Due to (or as a consequence of):
c. HYPERTENSION
Due to (or as a consequence of):
d. DIABETES

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings available prior to complation of cause of death? 1☐ Yas 2☐ No

25. Was case refarred to medical examiner? 1☐ Yas 2☒ No

26. Place of Death *(Check only ona)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Homa 5☐ Residanca 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Data of Injury *(Month, Day Year)*
28b. Time of Injury
M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Placa of Injury - At homa, farm, street, factory, office building, atc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On tha basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and dua to tha cause(s) and manner stated.

29b. Signature and titla of certifier: Sunita Hanjura MD
29c. License number: D 43272
29d. Data signed *(Month, Day, Year)*: NOVEMBER 13, 1998

30. Nama and address of person who completed causa of death (Item 23a) (Type, Print): SUNITA HANJURA, M.D. 809 VEIRS MILL ROAD #101 ROCKVILLE,MARYLAND 20851-1689

State Registrar

31. Data filed *(Month, Day, Year)*: NOV 16 1998
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37290

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*	2. Dete of Death Month Dey Yeer	3. Time of Death
Franklin Warren McCurdy	November 12, 1998	5:23 A.M.

4e Fecility Neme *(If not institution, give street end number)*	4b. City, Town, or Location of Deeth	4c. County of Deeth
Suburban Hospital	Bethesda	Montgomery

Funeral Director

5. Sociel Security Number	6. Sex	7. Age *(In yrs. lest birthday)*	If Under 1 Year Months / Deys	If Under 24 Hrs. Hours / Min.	8. Dete of Birth *(Month, Dey, Yeer)*	9. Birthplece *(Stete or Foreign Country)*
578-38-9299	1☒ M 2☐ F	90 Yrs.			July 18, 1908	Pennsylvania

Usuel Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Rockville	1☐ Yes 2☒ No

10e. Street end Number	10f. Zip Code	10g. Citizen of Whet Country?
14800 Lake Terrace	20853	United States

11. Marital Status	12. Wes Decedent Ever In U.S. Armed Forces?	13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indien, Bleck, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☒ Yes 2☐ No If Yes, Give Year or Detes: WW II	1☐ Yes 2☒ No *Specify:*	*Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*		16e. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*	16b. Kind of Business/Industry
Elementary/Secondery (0-12)	College (1-4or 5+)		
	5+	Personnel Specialist	U.S. Army

17. Fether's Neme *(First, Middle, Last)*	18. Mother's Name *(First, Middle, Maiden Sumeme)*
Franklin Warren McCurdy II	Mary Eisinger

19a. Informant's Name/Relationship *(Type, Print)*	19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*
Margaret E. McCurdy/Wife	14800 Lake Terrace, Rockville, Maryland 20853

20e. Method of Disposition	20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)* Date	20c. Location - City or Town, Stete
1☐ Burial 2☒ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*	Nov. 13, 1998 Montgomery Crematorium, Inc.	Bethesda, Maryland

21. Signature of Funeral Service Licensee	22. Neme end Address of Fecility
Robert Fam M00198	Robert A. Pumphrey Funeral Home / Rockville, Inc. 300 W. Montgomery Avenue, Rockville, Maryland 20850-2805

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one cause on eech line.

Approximate Intervel Between Onset end Deeth

Immediate Cause (Final disease or condition resulting in deeth)
e. CARDIOPULMONARY ARREST

Due to (or es e consequence of):
b. MYOCARDIAL INFARCTION

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest

Due to (or es e consequence of):
c.

Due to (or es e consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
GASTROINTESTINAL BLEEDING

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Piece of Death *(Check only one)*
Hospital: 1☐ Inpetient 2☒ ER/Outpetient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Deeth
1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*	28b. Time of Injury M	28c. Injury et Work? 1☐ Yes 2☐ No	28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*
1☑ **Certifying Physicien:** To the best of my knowledge, death occurred et the time, dete end place, end due to the ceuse(s) end manner es steted.
2☐ **Medical Examiner:** On the besis of examination end/or investigation, in my opinion, deeth occurred et the time, date and pleca, end due to the cause(s) end menner stated.

29b. Signature end title of certifier	29c. License number	29d. Date signed *(Month, Dey, Year)*
	D42135 MD	11-12-98

30. Neme end address of person who completed cause of death (Item 23e) (Type, Print)
DANY WESTERBAND M.D. 50 WEST EDMONSTON ST. ROCKVILLE

State Registrar

31. Date filed *(Month, Dey, Year)*	32. Registrer's Signature
NOV 16 1998	G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020
Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Released by Med. Examiner

MC Curdy, Franklin 11-12-58 5-23 PM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37299

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Joseph Maltz

2. Date of Death (Month, Day, Year): November 13 1998

3. Time of Death: 6:15 Am

4a. Facility Name *(If not institution, give street and number)*: 6812 Laverock Ct.

4b. City, Town, or Location of Death: Bethesda

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 115 05 2374

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 81 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: March 28 1917

9. Birthplace *(State or Foreign Country)*: new York

Usual Residence of Decedent

10a. State: MD

10b. County: Montgomery

10c. City, Town or Location: Bethesda

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10a. Street and Number: 6812 Laverock Ct.

10f. Zip Code: 20817

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 5

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Metallurgical Engineer

16b. Kind of Business/Industry: Science

17. Father's Name *(First, Middle, Last)*: Louis Maltz

18. Mother's Name *(First, Middle, Maiden Surname)*: Rose Singer

19a. Informant's Name/Relationship *(Type, Print)*: Wanda A. Maltz / Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6812 Laverock Ct. Bethesda Md. 20817

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [X] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, crematory or other place)*: George Washington Univ.Med.Ctr.

Date: 11/13/98

20c. Location - City or Town, State: Washington DC

21. Signature of Funeral Service Licensee: Clinton Reeder

22. Name and Address of Facility: Columbia Mortuary Services PO Box 58007 Washington DC 20037

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28d show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Pancreatic Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Peter B. Sherer MD

29c. License number: 21910

29d. Date signed *(Month, Day, Year)*: November 19, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Peter B. Sherer MD 3947 Ferrara Dr. Wheaton, MD 20906

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 20 1998

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37300

Physician / Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Donald Lee Miller

2. Date of Death (Month, Day, Year): November 7 1998

3. Time of Death: 11:00am

4a. Facility Name *(If not institution, give street and number)*: North Arundel Hospital

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 289-14-8921

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 73 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Dec 31, 1924

9. Birthplace *(State or Foreign Country)*: Kentucky

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Pasadena

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 314 Cockey Drive

10f. Zip Code: 21122

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1943-46

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): Collega (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Insurance Agent

16b. Kind of Business/Industry: Insurance

17. Father's Name *(First, Middle, Last)*: Theodore Miller

18. Mother's Name *(First, Middle, Maiden Surname)*: Little Lula Jernigan

19a. Informant's Name/Relationship *(Type, Print)*: Patricia L. Miller/Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 314 Cockey Drive Pasadena, MD 21122

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Meadowridge Cemetery

Date: 11-11-98

20c. Location - City or Town, State: Elkridge, Maryland

21. Signature of Funeral Service Licensee: ▶ Jean A Collins-Witzke

22. Name and Address of Facility: Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043

Physician / Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Ventricular fibrillation — minutes

Due to (or as a consequence of):

b. Hyperlipidemia — yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Sleep Apnea

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]

29c. License number: D-34868

29d. Date signed *(Month, Day, Year)*: November 9, 1998

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Diebold, Joanne 11055 Little Patuxent Parkway Columbia, MD 21044

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 10 1998

32. Registrar's Signature: ▶ Geneva G. Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

10
20 yet

DHMH 16 Rev 6/95

1. Linthicum T. Merson 2. November 10, 1998 3. 3:15 A.M.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 3730

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Linthicum Thomas Merson
2. Date of Death (Month, Dey, Yeer): November 10, 1998
3. Time of Death: 3:15 am
4a. Facility Neme (If not institution, give street end number): Charlotte Hall Veterans Home
4b. City, Town, or Location of Death: Charlotte Hall
4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 213-01-7620
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 84 Yrs. | If Under 1 Yeer: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Yeer): Jan 4, 1914
9. Birthplece (Stete or Foreign Country): Maryland

Usuel Residence of Decedent

10a. State: MD
10b. County: Howard
10c. City, Town or Location: Laurel
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street end Number: 9202 Gross Avenue
10f. Zip Code: 20723
10g. Citizen of Whet Country?: USA

11. Marital Stetus: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1941-45
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed): Elementery/Secondary (0-12): 8 | College (1-4or 5+):
16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Truck Mechanic
16b. Kind of Business/Industry: Federal Government

17. Father's Neme (First, Middle, Last): William Merson
18. Mother's Name (First, Middle, Maiden Surneme): Etta King

19a. Informent's Name/Reletionship (Type, Print): Susan Sherman /daughter
19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 9202 Gross Avenue, Laurel, Maryland 20723

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other place): Meadowridge Memorial Pk
Dete: 11/12
20c. Location - City or Town, Stete: Dorsey, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Neme end Address of Fecility: Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707-4389

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or hean failure. List only one cause on each line.

Approximete Interval Between Onset end Deeth

Immediate Cause (Final diseese or condition resulting in death)
a. RESPIRATORY FAILURE — few hrs
Due to (or as a consequence of):
b. ASPIRATION pneumonia — few day
Due to (or as a consequence of):
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury thet initieted events resulting in deeth) Lest
c. Mucus plugging
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
S/P TRACHEOSTOMY
CHRONIC OBSTRUCTIVE PULMONARY DISEASE
CEREBROVASCULAR ACCIDENT

23b. Did tobecco use contribute to the cauee of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24e. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No
24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical exeminer? 1 [ ] Yes 2 [X] No
26. Place of Deeth (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28e. Date of Injury (Month, Dey Yeer)
28b. Time of Injury M
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after daath.
To the Funeral Director: After this certificate has been signed by the attanding physician and completely filled in by the funeral director, pege 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1 [X] **Certifying Phyelcian**: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. 2 [ ] **Medical Examiner**: On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, date end plece, end due to the ceuse(s) end manner stated.
29b. Signature and title of certifier: [signature] ATTENDING
29c. License number: D-44436
29d. Date signed (Month, Dey, Yeer): NOV 10 1998
30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print): ASHVINKUMAR PATEL MD 6B PRESTON SQ II, WALDORF MD 20601

10 Ivet

State Registrar

31. Date filed (Month, Day, Year): NOV 12 1998
32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37302

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Dorothy Ann Miller
2. Deta of Death Month Day Year: November 9, 1998
3. Time of Deeth: 10:50 pm
4a. Facility Neme *(If not institution, give street end number)*: Mariner Health Care of Laurel
4b. City, Town, or Location of Death: Laurel
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 579-42-4861
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 65 Yrs. | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Dey, Year)*: November 5, 1933
9. Birthplece *(Steta or Foreign Country)*: Penn.

Usuel Residenca of Decedant

10a. Stata: Md.
10b. County: Anne Arundel
10c. City, Town or Location: Linthicum
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street end Number: 205 Mansion Road
10f. Zip Code: 21090
10g. Citizen of What Country?: USA
11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Raca - American Indien, Bleck, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highast grade completed)*: Elementary/Secondary (0-12): Grade 12 / College (1-4or 5+):
16a. Decedent's Usual Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Office Manager
16b. Kind of Businass/Industry: Government Sales & Consultants
17. Fathar's Name *(First, Middla, Last)*: Joseph Schneider
18. Mother's Name *(First, Middle, Meiden Surnema)*: (unknown)
19a. Informent's Neme/Relationship *(Type, Print)*: Don Darnall / son
19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 205 Mansion Road Linthicum, Maryland 21090
20a. Method of Disposition: 1☐ Buriel 2☒ Cramation 3☐ Removal from Stata 4☐ Donation 5☐ Othar *(Specify)*
20b. Piece of Disposition *(Name of cemetary, cremetory or other piece)*: Metro Crematory, Inc.
Deta: 11/10/98
20c. Location - City or Town, Stata: Catonsville, Md.
21. Signeture of Funeral Service Licensee: ▶ Guy E. Kay
22. Nama and Address of Facility: Donaldson Funeral Home, P.A. 313 Talbott Avenue Laurel, Maryland 20707

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on eech line.

Approximeta Intervel Between Onset and Deeth

Immediata Cause (Final disease or condition resulting in deeth)
e. CORONARY ARTERY DISEASE — 2 yrs

Due to (or es a consequence of):
b. ATHEROSCLEROSIS — 10 yrs

Sequentially list conditions, if any, laading to immedieta cause. Enter Underlying Cause (Disease or injury thet initiated evants rasulting in deeth) Lest

Dua to (or es e consequance of):
c.

Dua to (or es e consequance of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
CEREBROVASCULAR ACCIDENT
GASTROINTESTINAL BLEED

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings aveileble prior to completion of cause of deeth? 1☐ Yes 2☑ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☑ No

26. Piece of Deeth *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA; Other: 4☑ Nursing Homa 5☐ Residance 6☐ Other *(Specify)*

27. Menner of Deeth: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Phyeician:** To the best of my knowledge, daeth occurred at the time, dete end place, and dua to tha ceusa(s) end manner as steted. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, deeth occurred et the time, date end piece, end due to the cause(s) end menner steted.

29b. Signeture and title of certifier: ▶ Neil A. Meade MD
29c. Licanse number: D19220
29d. Dete signed *(Month, Day, Year)*: 11-10-98

30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print): Neil A. Meade 9811 Mallard Drive Laurel md 20708

State Registrar

31. Dete filed *(Month, Day, Year)*: NOV 12 1998
32. Registrer's Signeture: ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

10

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37303

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Marquerite Muhler

2. Date of Death: Month: November Day: 4 Year: 1998

3. Time of Death: 2:10 PM

4a. Facility Name (If not institution, give street and number): Laurel Regional Hospital

4b. City, Town, or Location of Death: Laurel

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 218-12-4348

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 91 Yrs.

If Under 1 Year: Months: Days: If Under 24 Hrs.: Hours: Min.:

8. Date of Birth (Month, Day, Year): Oct 10, 1907

9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: MD

10b. County: Howard

10c. City, Town or Location: Elkridge

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 290 Keeton Road

10f. Zip Code: 21227

10g. Citizen of What Country?: USA

11. Merital Status: 1☐ Never Merried 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yas 2☒ No If Yes, Give Yaar or Detas:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indien, Bleck, Whita, etc. Specify: White

15. Decedent's Education (Specify only highast grada completed): Elementery/Secondery (0-12): Grade 11 College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife

16b. Kind of Business/Industry: Own Home

17. Fathar's Name (First, Middle, Last): Gabriel D'Angelis

18. Mother's Name (First, Middle, Maiden Surnama): Kathryn Doyle

19a. Informent's Neme/Reletionship (Type, Print): Lisa M. Crosby / friend

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 11918 Gold Needle Way Columbia, Md. 21044

20a. Method of Disposition: 1☐ Buriel 2☒ Cremation 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Name of cemetery, cremetory or othar place): Metro Crematory, Inc.

Date: 11/10

20c. Location - City or Town, Stete: Catonsville, Maryland

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Facility: Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707-4389

Physician /Medical Examiner

23a. Part1. Entar the disease or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or raspiratory arrest, shock, or heert failure. List only one cause on eech line.

Approximete Interval Between Onset end Death

Immediate Causa (Finel diseasa or condition resulting in deeth):
a. Acute Myocardial Infarction — minutes

Due to (or as a consequence of):
b. Congestive Heart Failure — Hours

Sequentially list conditions, if any, leeding to immadiate cause. Enter Underlying Cause (Diseese or injury thet initiated events resulting in deeth) Lest

Due to (or es a consequence of):
c. Acute renal failure — Days —

Due to (or es e consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in tha underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings aveilable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical exeminer? 1☐ Yas 2☒ No

26. Place of Death (Check only one): Hospitel: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Rasidence 6☐ Other (Specify)

27. Manner of Deeth: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of tnjury (Month, Day Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of tnjury - At home, ferm, street, fectory, offica building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29e. Certifiar (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end piece, and due to the cause(s) end menner es stated. 2☐ **Medical Examiner:** On the besis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end piece, end due to the cause(s) end menner steted.

29b. Signature and title of certifier: ▶ William A Warren MD

29c. License number: D13916

29d. Date signed (Month, Day, Year): November 5, 1998

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): William A Warren MD 321 Prince George St Laurel, MD 20707

State Registrar

31. Date filed (Month, Day, Year): NOV 12 1998

32. Registrar's Signature: ▶ Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the deeth certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

2

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37304

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Walter, G., Milam
2. Dete of Deeth — Month: Nov — Dey: 10 — Yeer: 1998
3. Time of Death: 1:40 PM
4e. Fecility Neme *(If not institution, give street end number)*: Howard County General Hospital
4b. City, Town, or Location of Deeth: Columbia
4c. County of Deeth: Howard

Funeral Director

5. Sociel Security Number: 165-28-5428
6. Sex: 1 ☒ M 2 ☐ F
7. Age *(In yrs. lest birthday)*: 62 Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Dey, Yeer)*: Aug 6, 1936
9. Birthplece *(Stete or Foreign Country)*: West Virginia

Usuel Residence of Decedent

10a. Stete: Maryland
10b. County: Howard
10c. City, Town or Location: Columbia
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street end Number: 6005 Majors Lane Apt 12
10f. Zip Code: 21045
10g. Citizen of Whet Country?: United States
11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No — If Yes, Give Yeer or Detes: 1954-58
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*
14. Race - American Indien, Black, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grede completed)* — Elementery/Secondary (0-12): 12 — College (1-4or 5+):
16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Police Officer
16b. Kind of Business/Industry: Metro D.C. Police
17. Fether's Neme *(First, Middle, Last)*: Joshua Milam
18. Mother's Neme *(First, Middle, Maiden Surneme)*: Velma Pulliam
19a. Informent's Name/Relationship *(Type, Print)*: Barbara J. Milam/Wife
19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 6005 Majors Lane Columbia, Maryland 21045 Apt 12
20e. Method of Disposition: 1 ☐ Burial 2 ☒ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, cremetory or other place)*: Metro Crematory
Dete: 11-14-98
20c. Location - City or Town, State: Catonsville, MD
21. Signature of Funeral Service Licensee: ▶ Sean A Collins - Witzke
22. Neme end Address of Fecility: Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one ceuse on eech line. — Approximate Interval Between Onset end Death

Immediete Ceuse (Finel disease or condition resulting in deeth)
e. Myocardial Infarction — 10 hours
Due to (or es e consequence of):
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest
b.
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Pert II. **Other significant conditione** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24e. Wes en eutopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 1 ☐ Yes 2 ☐ No

25. Wes case referred to medical examiner? 1 ☐ Yes 2 ☑ No
26. Piece of Death *(Check only one)* — Hospital: 1 ☐ Inpetient 2 ☑ ER/Outpetient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*
27. Manner of Deeth: 1 ☑ Neturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28e. Dete of Injury *(Month, Dey Yeer)*
28b. Time of Injury M
28c. Injury et Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner es steted. 2 ☐ **Medical Examiner:** On the besis of exemination end/or investigation, in my opinion, death occurred et the time, date end plece, end due to the ceuse(s) end menner stated.

29b. Signeture end title of certifier: ▶ Rita E. King, MD F.A.C.C.
29c. License number: D0037155
29d. Date signed *(Month, Day, Year)*: Nov 10 1998

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): Rita E. King MD F.A.C.C. 11085 Little Patuxent Pkwy Columbia MD 21044

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 12 1998
32. Registrar's Signeture: ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

12/10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend #5, 357-24-6562,12/2/98,drw **Certificate of Death** Reg. No. 98 37305

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Dorothy M. McClure
2. Date of Death: Month Nov. Day 20, Year 1998
3. Time of Death: 8:25PM
4a. Facility Name (If not institution, give street and number): 7010 Woodyard Rd.
4b. City, Town, or Location of Death: Upper Marlboro
4c. County of Death: Pr. Geo.

Funeral Director

5. Social Security Number: 357-24-6562 ~~-257-24-6562~~
6. Sex: 1☐ M 2☐ F X
7. Age (In yrs. last birthday): 67 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 15,1931
9. Birthplace (State or Foreign Country): Illinois

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Upper Marlboro
10d. Inside City Limits: 1☐ Yes 2☐ No X
10e. Street and Number: 7010 Woodyard Road
10f. Zip Code: 20772
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary
16b. Kind of Business/Industry: PEPCO

17. Father's Name (First, Middle, Last): James Pendleton Tutt
18. Mother's Name (First, Middle, Maiden Surname): Marie E. Smith

19a. Interment's Name/Relationship (Type, Print): Dave A. McClure (Son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7010 Woodyard Road Upper Marlboro, Maryland 20772

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Lee Crematory — Date: Nov. 23, 1998
20c. Location - City or Town, State: Clinton, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd Clinton, MD 20735

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
e. LUNG CARCINOMA

Due to (or as a consequence of):
b. OBSTRUCTIVE PULMONARY DISEASE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
c. PULMONARY EMPHYSEMA

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
BONE METASTASES
MALNUTRITION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? No — 1☐ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? N/A — 1☐ Yes 2☐ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☐ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] Dr. of Lee MD
29c. License number: D15789
29d. Date signed (Month, Day, Year): 11-23-98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Danilo Lee, M.D. 7700 Old Branch Ave. D203 Clinton, Md. 20735

State Registrar

31. Date filed (Month, Day, Year): NOV 25 1998
32. Registrar's Signature: [signature]

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

15

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 07305

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Frances Irene Molder
2. Date of Death: Month Nov. Day 21 Year 1998
3. Time of Death: 8:04 AM
4a. Facility Name (If not institution, give street and number): Charlestown Care Center
4b. City, Town, or Location of Death: Catonsville
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 218-36-1360
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 86 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 30, 1912
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Catonsville
10d. Inside City Limits: 1☐ Yes 2☐ No
10e. Street and Number: 711 Maiden Choice Lane/ 211 Care Center
10f. Zip Code: 21228
10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 8; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Restaurant Owner
16b. Kind of Business/Industry: Hospitality

17. Father's Name (First, Middle, Last): Dominic Dituri
18. Mother's Name (First, Middle, Maiden Surname): Louisa Faimonda

19a. Informant's Name/Relationship (Type, Print): Valerie L. Cleaver - Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 117 Riverview Road, Stevensville, MD 21666

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): New Cathedral Cemetery — Date: Nov. 24, 1998
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Amy L Michiewicz
22. Name and Address of Facility: Fellows, Helfenbein & Newnam Funeral Home, P.A. 106 Shamrock Road Chester, MD 21619

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. end stage dementia — Years
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: aspiration pneumonitis

23b. Did tobacco uee contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings eveileble prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signeture and title of certifier: Myla M Carpenter MD
29c. License number: D30989
29d. Date signed (Month, Day, Year): November 21 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Myla M Carpenter MD 711 Maiden Choice Ln Catonsville MD

State Registrar

31. Date filed (Month, Dey, Year): NOV 24 1998
32. Registrar's Signeture: Jenna G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Name: Molder, Frances

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37307

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William Samuel Milholland

2. Data of Death: Month Nov. Dey 15 Year 1998

3. Time of Death: 12:57 P.M.

4e Facility Name (If not institution, give street and number): 222 Nichols Manor Road

4b. City, Town, or Location of Death: Stevensville

4c. County of Death: Queen Anne's

Funeral Director

5. Social Security Number: 215-34-8656

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 60 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Year): Feb. 26, 1938

9. Birthplace (State or Foreign Country): MD

Usual Residance of Decedent

10a. State: MD

10b. County: Queen Anne's

10c. City, Town or Location: Stevensville

10d. Inside City Limits: 1☐ Yes 2☐ No

10e. Street end Number: 222 Nichols Manor Road

10f. Zip Code: 21666

10g. Citizen of Whet Country?: U.S.A.

11. Maritai Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U,S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Yeer or Dates: 1955 1959

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed): Elementery/Secondary (0-12): 12 College (1-4or 5+):

16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Maintenance Improvement Officer

16b. Kind of Business/Industry: U.S. Postal Service

17. Fether's Name (First, Middle, Last): William S. Milholland

18. Mother's Name (First, Middle, Meiden Sumame): Anna Doonan

19a. Informent's Name/Reietionship (Type, Print): Monica A. Milholland - Wife

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 222 Nichols Manor Road, Stevensville, MD 21666

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other piece): Chesapeake Cremation Ctr. Date: Nov. 17, 1998

20c. Location - City or Town, State: Stevensville, MD

21. Signetyre of Funeral Service Licensee: Amy L Michaelis

22. Name end Address of Feciiity: Fellows, Helfenbein & Newnam Funeral Home 106 Shamrock Road, Chester, MD 21619

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that causad the death. Do not anter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line.

Approximete intervel Between Onset end Death

Immediate Ceuse (Final disease or condition resulting in deeth)
a. Lung cancer — 16 mos.

Due to (or as a consequenca of):

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated evants rasulting in daeth) Last
b.

Due to (or es a consequence of):
c.

Due to (or es e consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uee contribute to the cauee of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was en eutopsy performad? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medicai examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Placa of injury - At home, ferm, street, factory, office buiiding, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29e. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowiedge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end manner es stated. 2☐ **Medicai Examiner:** On the besis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: J. Selonick, MD

29c. License number: D19838

29d. Date signed (Month, Dey, Year): 11/16/98

30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print): Stuart E. Selonick 900 Bestgate Annapolis, Md. 21401

State Registrar

31. Dete filed (Month, Day, Year): NOV 18 1998

32. Registrer's Signeture: Jenna G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

19B

State of Maryland / Department of Health and Mental Hygiene

ITEMS: #10A-C, E-F PER G769 3-3-99 WR.

Certificate of Death

Reg. No. 98 37300

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day	Year	3. Time of Death
Irving	Nash	11	16	1998	1504

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
SHADY GROVE ADVENTIST HOSPITAL	ROCKVILLE	MONTGOMERY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
100 14 8654	1 [X] M 2 [ ] F	79 Yrs.			12 12 1918	New York

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD FL.	~~Montgomery~~ PALM BEACH	~~Silver Spring~~ BOYNTON BEACH	[XX] Yes 2 [ ] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
~~15107 Interlachen Drive #619~~ 5120 MIRROR LAKES BLVD.	~~20906~~ 33437	USA

11. Marital Status	12. Was Decedent Evar in U.S. Armed Forcas? If Yas, Give Yaar or Detes:	13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - Amarican Indian, Bleck, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	[XX] Yes 2 [ ] No WWII	1 [ ] Yes 2 [X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elamantary/Secondery (0-12)	College (1-4or 5+)		
	5+	Accountant	Federal Government

17. Fether's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maidan Surname)
Leon Nazimowitz	Fannie Leiber

19a. Informent's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City, Stata, Zip Code)
Rebecca Nash Wife	~~15107 Interlachen Drive #619, Silver Spring, MD 20906~~ 5120 MIRROR LAKES BLVD. BOYNTON BEACH FL 33437

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other pleca)	Date	20c. Location - City or Town, Stata
[XX] 1 Buriel 2 [ ] Cremation 3 [ ] Removel from State 4 [ ] Donation 5 [ ] Other (Specify)	Judean Memorial Gardens	11-20-98	Olney, MD

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name end Address of Facility: Danzansky-Goldberg Memorial Chapels, Inc 1170 Rockville Pike, Rockville, MD 20852

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not entar tha moda of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only ona cause on each line.

		Approximata Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Acute Arythmia	Minutes
	Due to (or as a consequenca of):	
Sequentiellly list conditions, if any, leeding to immedieta causa. Entar Underlying Ceuse (Disease or Injury that initiated events rasulting in death) Last	b.	
	Due to (or es e consequence of):	
	c.	
	Due to (or es a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobecco use contributa to the causa of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably [XX] Unknown

24a. Was an eutopsy performed?	24b. Wara autopsy findings available prior to completion of causa of death?
1 [ ] Yes 2 [XX] No	1 [ ] Yas 2 [ ] No

25. Wes case raferred to medical examiner?	26. Place of Deth (Check only one)	
1 [ ] Yas 2 [XX] No	Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA	Othar: 4 [ ] Nursing Home 5 [ ] Residenca 6 [ ] Other (Specify)

27. Mannar of Deth	28a. Dete of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1 [X] Naturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be datarmined		M	1 [ ] Yas 2 [ ] No	
	28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rurel Route Number, City or Town, Stata)

29a. Certifier (Check only one)
1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete end pleca, and due to the cause(s) and menner es stated.
2 [ ] **Medical Examiner:** On tha basis of examinetion and/or invastigation, in my opinion, death occurred at tha time, dete and placa, end due to the cause(s) and manner stated.

29b. Signature and title of cerdifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Brett Gamma MD	D5C980	November 16, 1998

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)
Brett Gamma, MD, 9901 Medical Center Dr, Rockville, MD 20850

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signatura
NOV 20 1998	[signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiena.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requiras that the death certificata be axecuted within 24 hours after death.
To the Funeral Director: After this certificata has been signed by the attending physician and completely filled in by tha funerel director, page 2 should be detached for use as the burial-transit

12

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37309

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Data of Deeth Month Day Year	3. Time of Death
TUONG VAN NGUYEN	NOVEMBER 9, 1998	2:30 PM

4a Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deeth	4c. County of Death
SUBURBAN HOSPITAL	BETHESDA	MONTGOMERY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Data of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
578-90-2811	1[X] M 2[ ] F	76 Yrs.			JUNE 7, 1922	VIETNAM

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Insida City Limits
MD	MONTGOMERY	BETHESDA	1[ ] Yas 2[X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
10205 FARNHAM DRIVE	20814	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, atc.)	14. Race - Amaricen Indian, Black, White, etc.
1[ ] Never Married 2[X] Married 3[ ] Widowed 4[ ] Divorced	1[ ] Yes 2[X] No If Yes, Give Year or Dates:	1[ ] Yes 2[X] No Specify:	Specify: ASIAN

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired)	16b. Kind of Businass/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	4	DIPLOMAT	VIETNAM GOVERNMENT

17. Father's Nama (First, Middle, Last)	18. Mothar's Name (First, Middle, Maiden Sumeme)
LINH NGUYEN	LUN THI PHAM

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)
LE THI NGUYEN / DAUGHTER	10205 FARNHAM DRIVE BETHESDA MARYLAND 20814

20a. Method of Disposition	20b. Place of Disposition (Name of cemetary, crematory or other place)	Data	20c. Location - City or Town, State
1[X] Burial 2[ ] Cremation 3[ ] Removal from Stata 4[ ] Donation 5[ ] Other (Specify)	GATE OF HEAVEN CEMETERY	11/13/98	SILVER SPRING, MD

21. Signature of Funeral Service Licensee	22. Nama and Addrass of Facility
▶ [signature]	HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVE SILVER SPRING MD 20904

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not entar the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

		Approximata Intarval Between Onset end Death
Immediata Cause (Final disease or condition resulting in death)	a. CARDIAC ARREST	ONE DAY
Due to (or es a consequence of):		
Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. VENTRICULAR TACHYCARDIC	FIVE YEAR
Due to (or as a consequence of):		
	c. CHRONIC PANCREATITIS	ONE YEAR
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1[ ] Yes 2[X] No 3[ ] Probably 4[ ] Unknown

24a. Was an autopsy performed?	24b. Wara autopsy findings eveilable prior to completion ot ceuse of death?
1[ ] Yas 2[X] No	1[ ] Yes 2[ ] No

25. Was case refarred to medical examiner?	26. Place of Deeth (Check only one)	
1[ ] Yes 2[X] No	Hospital: 1[ ] Inpatient 2[X] ER/Outpatient 3[ ] DOA	Other: 4[ ] Nursing Homa 5[ ] Rasidence 6[ ] Othar (Specify)

27. Manner of Death	28a. Data of Injury (Month, Day Year)	28b. Tima of Injury	28c. Injury at Work?	28d. Dascribe how injury occurred
1[X] Natural 2[ ] Accident 3[ ] Suicide 4[ ] Homicide 5[ ] Pending investigation 6[ ] Could not be datarmined		M	1[ ] Yas 2[ ] No	
	28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rurel Route Number, City or Town, Stata)

29a. Certifier (Check only one) 1[X] **Certifying Physician:** To the best of my knowledge, death occurred at tha time, date and piece, end due to tha cause(s) end mannar as stated. 2[ ] **Medical Examiner:** On the basis of examination end/or invastigation, in my opinion, daath occurred at tha tima, data and piece, and dua to the ceuse(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Data signed (Month, Day, Year)
▶ [signature] MD	D34969	11-13-1998

30. Name and sddress of person who completed cause of death (Item 23a) (Type, Print)

H. Victor Chiang M.D. 9707 Medical Center Dr. Rockville, Md 20850

To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attanding physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Data filed (Month, Day, Year)	32. Registrar's Signature
NOV 16 1998	[signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37310

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Agnes Louise Nelson
2. Date of Death (Month, Day, Year): Nov. 7, 1998
3. Time of Death: 8:40a.m.
4a. Facility Name *(If not institution, give street and number)*: Kent & Queen Anne's Hospital
4b. City, Town, or Location of Death: Chestertown
4c. County of Death: Kent

Funeral Director

5. Social Security Number: 218-16-7328
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Apr.12,1924
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Md.
10b. County: Queen Anne's
10c. City, Town or Location: Centreville
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 418 Railroad Ave.
10f. Zip Code: 21617
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11 | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Clerk/Cashier
16b. Kind of Business/Industry: Grocery Store

17. Father's Name *(First, Middle, Last)*: Howard Edward Whitby
18. Mother's Name *(First, Middle, Maiden Surname)*: Agnes Jane Johnson

19a. Informant's Name/Relationship *(Type, Print)*: Charles S. Nelson-Husband
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 418 Railroad Ave., Centreville, Md. 21617

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Chesterfield Cemetery | Date: Nov.9, 1998
20c. Location - City or Town, State: Centreville, Md.

21. Signature of Funeral Service Licensee: Chad M. Helfenbein
22. Name and Address of Facility: Fellows, Helfenbein & Newnam Funeral Home 408 S. Liberty St., Centreville, Md. 2161

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) e.	Cardiopulmonary arrest	1 min.
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.	Liver metastatic cancer	1-3 mo's
Due to (or as a consequence of):		
c.	Hepatic encephalopathy	1 week
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I: HTN

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D51735
29d. Date signed *(Month, Day, Year)*: 11/9/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Frederick Delboy, M.D.; 6602 Church Hill Rd., Suite 200, Chestertown, Md.21620

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 10 1998
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37311

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Abbie Eleanor Nash

2. Date of Death Month / Day / Year: October 19, 1998

3. Time of Death: 2:00a.m.

4a. Facility Name *(If not institution, give street and number)*: 101 Morgnec Road

4b. City, Town, or Location of Death: Chestertown

4c. County of Death: Kent

Funeral Director

5. Social Security Number: 166-14-3669

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 78 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: January 29, 1920

9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Kent

10c. City, Town or Location: Chestertown

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 101 Morgnec Road

10f. Zip Code: 21620

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Harry Luther Hinkleman

18. Mother's Name *(First, Middle, Maiden Surname)*: Abbie Quigle

19a. Informent's Name/Relationship *(Type, Print)*: William Henry Nash/Husband

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 101 Morgnec Road, Chestertown, MD 21620

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Ft. Lincoln Cemetery

Date: 10/22/98

20c. Location - City or Town, State: Brentwood, Maryland

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Facility: Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, MD 21620

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Spinal Tumor — 3 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] MD

29c. License number: D41587

29d. Date signed *(Month, Day, Year)*: 11/23/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Helen A. Noble 122 Speer Road, Suite 5, Chestertown, MD 21620

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 30 1998

32. Registrar's Signature: ▶ [signature] G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37312

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Johanna M. Oleinik
2. Date of Death Month Day Year: November 11, 1998
3. Time of Death: 6:25 PM
4e Facility Neme (If not institution, give street and number): 2 Sedgwick Lane
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 479-09-7816
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 81 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 13,1917
9. Birthplace (State or Foreign Country): Iowa

Usual Residence of Decedent

10a. Stete: Maryland
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2 Sedgwick Lane
10f. Zip Code: 20852
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Neme (First, Middle, Last): Henry Post
18. Mother's Name (First, Middle, Maiden Surname): Bertha ter Burg

19a. Informant's Neme/Reletionship (Type, Print): Joseph J. Oleinik (husband)
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2 Sedgwick Lane, Rockville,Maryland 20852

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gate of Heaven Cemetery
Date: 11/16/98
20c. Location - City or Town, State: Silver Spring,Maryland

21. Signature of Funeral Service Licensee: James Stein
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd.,West,Silver Spring,MD 20901

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the diseese, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heert feilure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Ceuse (Final diseese or condition resulting in deeth)
a. PULMONARY ARTERIAL THROMBOEMBOLUS

Due to (or as e consequence of):
b. AMPUTATION LFT. LOWER LEG

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last
Due to (or es e consequence of):
c. FRACTURE LFT. FEMUR

Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
MRSI LFT. FEMUR

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an eutopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Deeth: 1☐ Neturel 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Date of Injury (Month, Day Year): AUGUST 15 1998
28b. Time of Injury: 09 00 M
28c. Injury et Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: FELL AT HOUSE
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify): HOME
28f. Location (Street and Number or Rural Route Number, City or Town, Stete): 2 SEDGEWICK LANE ROCKVILLE, MD 20852

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end manner steted.
29b. Signature and title of certifier: MD. (OME)
29c. License number: 015236
29d. Date signed (Month, Day, Year): NOVEMBER 12, 1998

30. Neme end eddress of person who completed cause of death (Item 23a) (Type, Print): CARL I. MARGOLIS, MD 11125 ROCKVILLE PIKE, ROCKVILLE, MD 20852

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

4

State Registrar

31. Date filed (Month, Day, Year): NOV 16 1998
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37313

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Irma Edwards Orletsky	November 16, 1998	9:45 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
9015 Bradford Road	Silver Spring	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-60-0775	1☐ M 2☒ F	89 Yrs.			Sept.1, 1909	Washington, DC

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Montgomery	Silver Spring	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
9015 Bradford Road	20901	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	2	Bond Clerk	US Government

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Frank Edwards	Hattie May

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Glenn Orletsky (son)	1 Clover Hill Court, Olney, MD 20832

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Metropolitan Crematory	11/17/98	Alexandria, Virginia

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Steven D Stencil	Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter tha diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heert fellura. List only one cause on eech line.

		Approximata Intervel Between Onset and Daath
Immediate Cause (Finel disaase or condition resulting in death)	a. Respiratory Failure	
	Due to (or es e consequence of):	
Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in death) Lest	b. Chronic Obstructive Lung Disease	
	Due to (or as e consequence of):	
	c. Osteoporosis	
	Due to (or es e consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed?	24b. Were eutopsy findings eveilable prior to completion of cause of deeth?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Wes case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yas 2☒ No	Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Menner of Death	28a. Dete of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) end menner es steted.
2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred et the time, dete end place, and due to the ceuse(s) end manner steted.

29b. Signature and title of certifier	29c. License number	29d. Data signed (Month, Dey, Year)
▶	D19400	November 17, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Ernesto Africano, M.D. 831 University Blvd., Silver Spring, MD 20903

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Dete filed (Month, Dey, Year)	32. Registrar's Signatura
NOV 18 1998	Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37314

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Seymour David Osheroff
2. Date of Death Month Dey Yeer: November 17, 1998
3. Time of Death: 2:50 PM
4a. Facility Name (If not institution, give street end number): 322 Hannes Street
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-46-5743
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 62 Yrs.
If Under 1 Year: Months / Deys
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Year): January 1, 1936
9. Birthplace (State or Foreign Country): Pennsylvania

Usuel Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street end Number: 322 Hannes Street
10f. Zip Code: 20910
10g. Citizen of Whet Country?: U.S.A.

11. Maritel Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed)
Elementary/Secondary (0-12):
College (1-4or 5+): 5+
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Pharmacist
16b. Kind of Business/Industry: Pharmacy

17. Fether's Neme (First, Middle, Last): Ben Osheroff
18. Mother's Name (First, Middle, Maiden Surneme): Gussie Rose

19a. Informent's Name/Relationship (Type, Print): Deena Osheroff/ Wife
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 322 Hannes St., Silver Spring, MD 20910

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Piece of Disposition (Name of cemetery, cremetory or other piece): Judean Memorial Gardens
Date: 11/18/98
20c. Location - City or Town, State: Olney, MD

21. Signature of Funeral Service Licensee: [signature]
22. Neme end Address of Facility: Ives-Pearson Funeral Home, 2847 Wilson Blvd., Arlington, VA 22201

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Meryland Department of Health end Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Dmw

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Pert1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on each line.

Approximate Intervel Between Onset end Deeth

Immediate Ceuse (Finel disease or condition resulting in death)
e. Metastatic Pancreatic Cancer — 6 months

Due to (or es e consequence of):

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in deeth) Lest
b.
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Pert II. **Other significant conditione** contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. **Did tobecco uee contribute to the cause of death?** 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Were eutopsy findings aveileble prior to completion of ceuse of deeth? 1 [ ] Yes 2 [X] No

25. Wes cese referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Deeth (Check only one)
Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA
Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Menner of Deeth: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physicien:** To the best of my knowledge, death occurred at the time, dete end piece, end due to the ceuse(s) end manner es steted. 2 [ ] **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) and menner stated.

29b. Signature end title of certifier: [signature] Linda M Burrell
29c. License number: D35996
29d. Dete signed (Month, Dey, Year): 11-18-98

30. Neme end eddress of person who completed cause of death (Item 23a) (Type, Print): Linda Burrell M.D. 2101 Medical Pk Dr #210 Silver Spring, MD 20902

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificete be executed within 24 hours efter death.
To the Funeral Director: After this certificete hes been signed by the attending physician end completely filled in by the funeral director, pege 2 should be detached for use es the burial-transit

10

State Registrar

31. Dete filed (Month, Day, Year): NOV 18 1998
32. Registrer's Signeture: [signature] B. Sparks

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

AMENDED # 18, 11/24/98, EPW, WOR .CO

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37315

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
MELVIN HOLLAND PARKER	11	21	98	0854

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Atlantic General Hospital	Berlin	Worcester

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-12-2420	1 [X] M 2 [ ] F	87 Yrs.			10/10/11	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Worcester	Ocean City	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
10321 Keyser Point RD	21842	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
6		Farmer	Farming

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Thomas Parker	Anna (~~Unknown~~) Mitchell

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Della C. Parker/ Wife	10321 Keyser Point RD Ocean City, MD 21842

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Sunset Memorial Park	11/24/98	Berlin, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
W. Bird Burbage	Burbage Funeral Home 108 William St. Berlin, MD 21811

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Coronary Artery Disease	
	Due to (or as a consequence of): Congestive Heart Failure	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown	1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1 [ ] Yes 2 [X] No	Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death	28e. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Stephen W. Waters MD	D27993	11-23-98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Stephen F. Waters, MD 10th St. Ocean City, MD 21842

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 23 1998	Geneva G. Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37316

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mary Cannon Pitt
2. Dete of Deeth — Month: November Dey: 14 Yeer: 1998
3. Time of Deeth: 4:06 PM
4a Fecility Name *(If not institution, give street end number)*: 11909 Enid Drive
4b. City, Town, or Location of Deeth: Potomac
4c. County of Deeth: Montgomery

Funeral Director

5. Sociel Security Number: 578 24 3038
6. Sex: 1☐ M 2☒ F
7. Age *(in yrs. lest birthday)*: 85 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Dey, Yeer)*: January 18 1913
9. Birthplace *(Stete or Foreign Country)*: Washington DC

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Potomac
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 11909 Enid Drive
10f. Zip Code: 20854
10g. Citizen of Whet Country?: USA

11. Maritel Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Ricen, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+): 5+
16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Teacher
16b. Kind of Business/Industry: Education

17. Fether's Neme *(First, Middle, Last)*: Luther Sidney Cannon
18. Mother's Name *(First, Middle, Maiden Surneme)*: Minna Atkinson

19a. Informant's Name/Relationship *(Type, Print)*: William Cannon Pitt/ SON
19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 11909 Enid Drive Potomac Md. 20854

20e. Method of Disposition: 1☐ Burial 2☐ Cremetion 3☐ Removel from Stete 4☒ Donetion 5☐ Other *(Specify)*
20b. Place of Disposition *(Neme of cemetery, cremetory or other place)*: George Washington Univ. Med.Ctr. — Date: 11/14/98
20c. Location - City or Town, Stete: Washington DC

21. Signature of Funerel Service Licensee: Clinton Crosby
22. Name end Address of Fecility: Columbia Mortuary Services, PO Box 58007 Washington DC 20037

Physician /Medical Examiner

23a. Part I. Enter the disease, or complicetions that caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart feilure. List only one ceuse on each line. — Approximete Intervel Between Onset end Death

Immediate Ceuse (Finel disease or condition resulting in deeth)
e. RECTAL CARCINOMA
Due to (or es e consequence of):
b. LUNG METASTASES

Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest
Due to (or as e consequence of):
c.
Due to (or es e consequence of):
d.

Pert II. **Other significant conditione** contributing to death but not resulting in the underlying ceuse given in Part I.: Monoclonal gammopathy

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yee 2☒ No 3☐ Probably 4☐ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Wes cese referred to medical examiner? 1☐ Yes 2☒ No

26. Piece of Deeth *(Check only one)*: Hospital: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28e. Dete of Injury *(Month, Dey Yeer)* — 28b. Time of Injury M — 28c. Injury et Work? 1☐ Yes 2☐ No — 28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)* — 28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end piece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, date end place, end due to the cause(s) end menner stated.

29b. Signature end title of certifier: Jonathan Plotsky MD
29c. License number: D38589
29d. Date signed *(Month, Dey, Yeer)*: November 16 1998

30. Name and address of person who completed ceuse of deeth (Item 23e) (Type, Print): Jonathan Plotsky 15225 Shady Grove Rd. Ste 102 Rockville Md. 20850

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: NOV 18 1998
32. Registrer's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 37317

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mary Louise Payne

2. Data of Death — Month: NOVEMBER — Day: 6, — Year: 1998

3. Time of Death: 0415

4a. Facility Name *(If not institution, give street and number)*: ST. AGNES HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: None

Funeral Director

5. Social Security Number: 215-01-1687

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 84 Yrs.

If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 29, 1914

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Woodlawn

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 7257 Fairbrook Road

10f. Zip Code: 21244

10g. Citizen of What Country?: United States

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): — College (1-4 or 5+): 2

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Secretary

16b. Kind of Business/Industry: Life Insurance

17. Father's Name *(First, Middle, Last)*: Alonzo F. Payne

18. Mother's Name *(First, Middle, Maiden Surname)*: Lucy Gray

19a. Informant's Name/Relationship *(Type, Print)*: Tom Payne/Nephew

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3323 Hibiscus Court Ellicott City, MD 21043

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: New Cathedral Cemetery — Date: 11-9-98

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Dawn A Collins-Witzke

22. Name and Address of Facility: Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ASPIRATION PNEUMONIA — 2 WEEKS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION
CONGESTIVE HEART FAILURE
ATRIAL FIBRILLATION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: P 12597

29d. Date signed *(Month, Day, Year)*: NOVEMBER 6, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): WORLALI NUTAKOR, ST. AGNES HOSPITAL, 900 CATON AVE. BALTIMORE, MD 21229

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 10 1998

32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME: PAYNE, Mary L
Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37310

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
DRURY	COLLINSON	PLUMMER	November 18, 1998	19:15p

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Calvert Memorial Hospital	Prince Frederick	Calvert

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
577 09 9898	1☒ M 2☐ F	83 Yrs.			Apr. 2, 1915	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Calvert	Dunkirk	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3520 Lyons Creek Road	20754	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☒ Yes 2☐ No If Yes, Give Year or Dates: 1941-45	1☐ Yes 2☒ No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		switchboard installer	telephone

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Robert Carr Plummer	Marion Collinson

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mrs. Isabelle P. Plummer / wife	same as # 10 above

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	So. Memorial Gerdens	11-20-98	Dunkirk, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ William R. Rausch	Rausch Funeral Home, P.A., Owings, MD 20736

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Acute MI.	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Coronary artery disease	2 months
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic renal failure

23b. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown	1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Zahir Yousaf	D27189	11.19.98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Zahir Yousaf 2417 Solomons Island Road Huntingtown, Md 20639

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 20 1998	▶ [signature] G. Sparks

DHMH 16 Rev 6/95

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1 VA

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend #7, 11/17/98, BMW, Montg.Co.

Certificate of Death

Reg. No. 98 97319

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Sylvesta Roach Roberts

2. Date of Death (Month, Day, Year): NOVEMBER 13, 1998

3. Time of Death: 11:55 AM

4a. Facility Name (If not institution, give street and number): Brooke Grove Nursing and Rehabilitation Ctr

4b. City, Town, or Location of Death: Sandy Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 230-01-6805

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): ~~85~~ 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 30, 1911

9. Birthplace (State or Foreign Country): South Carolina

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: Montgomery

10c. City, Town or Location: Sandy Spring

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 18430 Brook Grove Road

10f. Zip Code: 20860

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Assistant Librarian

16b. Kind of Business/Industry: Montgomery County Public Schools

17. Father's Name (First, Middle, Last): James A. Roach

18. Mother's Name (First, Middle, Maiden Surname): Viola Arthurine

19a. Informant's Name/Reletionship (Type, Print): Karen S. Roberts Franklin

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1000 Tanley Road Silver Spring, Maryland 20904

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removel from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Parklawn Memorial

Date: 11/17/98

20c. Location - City or Town, State: Rockville, Maryland

21. Signature of Funeral Service Licensee: Marvin E. Heath

22. Name and Address of Facility: McGuire Funeral Service, Inc. 20012, 7400 Georgia Avenue, N.W. Washington, D.C.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the diseese, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ASPIRATION PNEUMONIA. — 3 DAYS

Due to (or as a consequence of):

b. DYSPHAGIA — MONTHS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. ADVANCE SENILE DEMENTIA

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

DIABETES MELLITUS

23b. Did tobacco uae contribute to the cauae of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was en eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Piece of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: Ted Howe. MD

29c. License number: D33700

29d. Date signed (Month, Day, Year): NOVEMBER 16, 1998

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): TED HOWE 7542 OVERLOOK DR. BOONSBORO, MD 21713

State Registrar

31. Date filed (Month, Day, Year): NOV 17 1998

32. Registrar's Signature: Geneva G. Sparks

To be completed by the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend #8, 11/19/98, BMW, Montgomery Co. — *Certificate of Death* — Reg. No. 98 37320

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EVA ROTH
2. Date of Death (Month, Day, Year): November 16, 1998
3. Time of Death: 4:50 PM
4a. Facility Name (If not institution, give street and number): Hebrew Home Of Greater Washington
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 578-50-0424
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 88 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): ~~Nov. 16, 1998~~ 7-10-10
9. Birthplace (State or Foreign Country): Poland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 6121 Montrose Road
10f. Zip Code: 20852
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4or 5+): 4 Years
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Jacob Braun
18. Mother's Name (First, Middle, Maiden Surname): Spicehandler

19a. Informant's Name/Relationship (Type, Print): Jacob B. Roth, Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7502 Lilac Sea, Columbia, Maryland 21046

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory, or other place): B'nai Israel Congregation Cemetery
Date: November 19, 1998
20c. Location - City or Town, State: Oxon Hill, Maryland

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: STEIN HEBREW MEMORIAL FUNERAL HOME, INC. 232 CARROLL STREET, NW, WASHINGTON, DC 20012

bmw

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions thet ceused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one ceuse on each line.

Approximete Interval Between Onset end Death

Immediete Ceuse (Finel diseese or condition resulting in deeth)
e. CVA — 2 MONTHS

Due to (or es e consequence of):
b. ATRIAL FIBRILLATION — YEARS

Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury thet initieted events resulting in deeth) Lest
Due to (or as e consequence of):
c. CORONARY ARTERY DISEASE — YEARS

Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.
CLOSTRIDIUM DIFFICILE ENTERITIS

23b. Did tobacco use contribute to the cauee of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings eveilable prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Wes cese referred to medical examiner? 1☒ Yes 2☐ No

26. Plece of Deeth (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, dete end plece, and due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end plece, end due to the ceuse(s) end manner stated.

29b. Signature end title of certifier: ▶ Steven Lipson MD
29c. License number: D05885
29d. Date signed (Month, Day, Year): 11/17/98

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print): STEVEN LIPSON 6121 MONTROSE RD, ROCKVILLE

State Registrar

31. Dete filed (Month, Day, Year): NOV 19 1998
32. Registrer's Signeture: Geneva G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37321

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): DIANE BEAHM ROSS

2. Dete of Death: Month NOV. Dey 16 Yeer 1998

3. Time of Death: 10:25 AM

4e. Facility Name (If not institution, give street end number): Shady Grove Rehabilitation Center

4b. City, Town, or Location of Death: Rockville

4c. County of Deeth: Montgomery

Funeral Director

5. Social Security Number: 577-44-3973

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 66 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Dey, Yeer): Apr.29, 1932

9. Birthplace (State or Foreign Country): Washington D C

Usual Residence of Decedent

10e. Stete: Maryland

10b. County: Montgomery

10c. City, Town or Location: Brookeville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 1030 Hawlings Road

10f. Zip Code: 20833

10g. Citizen of Whet Country?: United States

11. Maritel Stetus: 1☐ Never Merried 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed): Elementary/Secondery (0-12): 12 | College (1-4or 5+): 2

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Executive Secretary

16b. Kind of Business/Industry: U.S. Dept. of Army

17. Fether's Neme (First, Middle, Last): Wesley Beahm

18. Mother's Neme (First, Middle, Meiden Surname): Constance Orphanous

19e. Informent's Name/Relationship (Type, Print): Robert B. Ross/ husband

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 1030 Hawlings Road, Brookeville, Maryland 20833

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Salem Cemetery

Dete: 11/20/98

20c. Location - City or Town, Stete: Brookeville, Maryland

21. Signeture of Funeral Service Licensee: ▶ Muriel H. Barber

22. Neme end Address of Fecility: Muriel H. Barber Funeral Home P.O. Box 5038, Laytonsville, Maryland 20882

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Death

Immediete Ceuse (Finel disease or condition resulting in deeth)
e. ASTROCYTOMA — 3 Months

Due to (or es e consequenca of):

Sequentielly list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting in deeth) Lest
b.

Due to (or es e consequence of):
c.

Due to (or es e consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

Coronary Artery Disease
Diabetes Mellitus
Bronchial Asthma

23b. Did tobacco use contribute to the cauee of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residenca 6☐ Other (Specify)

27. Manner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28e. Dete of Injury (Month, Dey Yeer)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, date end placa, end due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier: ▶

29c. License number: D 28656

29d. Date signed (Month, Dey, Yeer): NOV. 16, 1998

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): RAVI PASSI MD. 8609 SECOND AVE #404 B. SILVER SPRING MD 20910

State Registrar

31. Date filed (Month, Dey, Yeer): NOV 18 1998

32. Registrer's Signeture: G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend #19a, 11/23/98, BMW, Montg.Co.

Certificate of Death

Reg. No. 98 37322

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Miriam Roshwald	Nov. 13, 1998	11:45am

4e. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
8811 Colesville Road #502	Silver Spring	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
477-44-0950	1☐ M 2☒ F	72 Yrs.			Dec. 23, 1925	Poland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Montgomery	Silver Spring	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
8811 Colesville Road #502	20910	USA

11. Marital Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	5+	Teacher& Writer	Education

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Shlomo Wyszynski	Mandzia Friedman

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mordecai M. Roshwald -spouse ~~Mordecai Roshwald-spouse~~	8811Colesville Rd. #502 Silver Spring, MD 20910

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Judean Memorial Gardens	11/16/98	Olney, MD

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility: Danzansky Goldberg Memorial Chaples, Inc. 1170 Rockville Pike Rockville, MD 20852

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. OVARIAN CARCINOMA	21 months
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signature and Title of Certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature] MD	D 35635	November 15, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph Kaplow 19111 Prince Phil., Dr Olney, MD 20832

State Registrar

31. Dete filed (Month, Dey, Year)	32. Registrer's Signature
NOV 17 1998	Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37323

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Dorothy L. Robinson

2. Date of Death Month Day Year: November 14, 1998

3. Time of Death: 9:50 PM

4a. Facility Name *(If not institution, give street and number)*: Mariner Health Care - Silver Spring

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 228-03-4892

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 80 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: March 19, 1918

9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: NY

10b. County: Erie

10c. City, Town or Location: Buffalo

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 124 Fulton Street, 6-H

10f. Zip Code: 14201

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Nanny

16b. Kind of Business/Industry: Domestic

17. Father's Name *(First, Middle, Last)*: William Lewis Carter

18. Mother's Name *(First, Middle, Maiden Surname)*: Laura White

19a. Informant's Name/Relationship *(Type, Print)*: Joy B. Petersen (granddaughter)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6404 85th Place, New Carrollton, MD 20784

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Forest Lawn Cemetery

Date: 11/21/98

20c. Location - City or Town, State: Buffalo, NY

21. Signature of Funeral Service Licensee: ▶ J Kevin Skiles

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Pneumonia — 3 weeks

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

possible lung cancer
dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Barry Rosenbaum, M.D.

29c. License number: D09834

29d. Date signed *(Month, Day, Year)*: 11/16/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BARRY ROSENBAUM 3720 FARRAGUT AVE. KENSINGTON, MD 20895

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 17 1998

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend #26, 11/17/98, BMW, Montg.Co.

Certificate of Death

Reg. No. 98 37324

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Sallie Brubeck Riley
2. Date of Death (Month, Day, Year): November 10, 1998
3. Time of Death: 12:01 AM
4a. Facility Name (If not institution, give street and number): 8608 Pete Wiles Road
4b. City, Town, or Location of Death: Middletown
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 236-32-4501
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 91 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 4, 1907
9. Birthplace (State or Foreign Country): West Virginia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 9905 Merwood Lane
10f. Zip Code: 20901
10g. Citizen of What Country?: USA
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): | College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Teacher
16b. Kind of Business/Industry: Education
17. Fether's Name (First, Middle, Last): James Arthur Brubeck
18. Mother's Name (First, Middle, Maiden Surname): Lucy Temple Henderson
19a. Informent's Name/Reletionship (Type, Print): Charles A. Shields (son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11817 Charles Road, Silver Spring, MD 20906
20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Name of cemetery, crematory or other place): Sunset Memorial Park
Date: 11/14/98
20c. Location - City or Town, Stete: Beckley, WV
21. Signature of Funeral Service Licensee: Steven D. Stroud
22. Neme end Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Interval Between Onset and Death

Immediete Cause (Final disease or condition resulting in deeth): e. Gastric Cancer — months

Due to (or as a consequence of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Last

b. Due to (or es a consequence of):

c. Due to (or as a consequence of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ ~~Residence~~ 6☒ Other (Specify) Second residence

27. Manner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, tectory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and menner es steted. 2☐ **Medical Examiner:** On the besis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner steted.

29b. Signature and title of certifier: HEGAZI, MD
29c. License number: D44164
29d. Date signed (Month, Day, Year): 11-11-98

30. Neme end address of person who completed ceuse of deeth (Item 23a) (Type, Print): 301 TOLLHOUSE AVE, Bld D-3, Frederick MD 21701 A. Zakaria Hegazi

State Registrar

31. Date filed (Month, Day, Year): NOV 17 1998
32. Registrar's Signature: B. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

15

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Grace Cantrell Reynolds
2. Date of Death: Month Nov 24 Day 1998 Year
3. Time of Death: 1:30 PM
4a. Facility Name *(If not institution, give street and number)*: Solomons Nursing Center
4b. City, Town, or Location of Death: Solomons
4c. County of Death: Calvert

Funeral Director

5. Social Security Number: 579 46 0034
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 90 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: June 28 1908
9. Birthplace *(State or Foreign Country)*: Tennesse

Usual Residence of Decedent

10a. State: Florida
10b. County: Duval
10c. City, Town or Location: Jacksonville
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1071 South Edgewood Ave.
10f. Zip Code: 32205
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces?: 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Editor
16b. Kind of Business/Industry: Civil Service US Government

17. Father's Name *(First, Middle, Last)*: Baxter J. Cantrell
18. Mother's Name *(First, Middle, Maiden Surname)*: Roxie Bell

19a. Informant's Name/Relationship *(Type, Print)*: Harold Reynolds - son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: P.O. Box 273 Topping Virginia 23169

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gethsemane Memorial Gardens — Date: Nov 28 1998
20c. Location - City or Town, State: Morehead City North Carolina

21. Signature of Funeral Service Licensee: BRausch
22. Name and Address of Facility: Rausch Funeral Home PA 4405 Broomes Is. Rd. Port Republic MD 20676

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Sepsis — unk

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last:
b. General Debility and poor Nutritional Status
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Breast cancer

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier
29c. License number: D33123
29d. Date signed *(Month, Day, Year)*: 11-25-98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jonathan Lowenthal, M.D. 110 Hospital Rd, Ste. 310, Prince Frederick, MD 20678

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 25 1998
32. Registrar's Signature: Penny B. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend #7, 11/17/98, BMW, Montg.Co. — *Certificate of Death* — Reg. No. 98 37326

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARY SCOTT
2. Dete of Death Month / Dey / Yeer: NOVEMBER 10, 1998
3. Time of Deeth: 05:35 PM
4a. Feclity Name *(If not institution, giva street and number)*: PRINCE GEORGES HOSPITAL CENTER
4b. City, Town, or Location of Death: CHEVERLY
4c. County of Deeth: PRINCE GEORGES

Funeral Director

5. Social Security Number: 579-32-4584
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. lest birthday)*: 72 ~~69~~ Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Dey, Yeer)*: Dec. 18, 1925
9. Birthplece *(Stete or Foreign Country)*: Bishopville, SC

Usuel Residance of Decedent

10a. State: DC
10b. County:
10c. City, Town or Location: Washington
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street end Number: 910 Eastern Ave., N.E. #104
10f. Zip Code: 20019
10g. Citizen of Whet Country?: USA
11. Marital Status: 1☐ Navar Marriad 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yas 2☒ No If Yes, Give Yaar or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Rece - Americen Indien, Black, White, etc. *Specify:* Black
15. Decedent's Educetion *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10th — College (1-4or 5+):
16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Nursing Assistant
16b. Kind of Business/Industry: Private
17. Fether's Neme *(First, Middle, Last)*: Luther Frison
18. Mother's Neme *(First, Middle, Maiden Sumame)*: Sophie Ben
19a. Informent's Name/Reletionship *(Type, Print)*: Jacqueline Day - Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 910 Eastern Ave., NE #104 Washington, DC 20019
20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Remaval from Stata 4☐ Donetion 5☐ Othar *(Specify)*
20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*: Lincoln Memorial
Date: 11/16/98
20c. Location - City or Town, Stete: Suitland, MD
21. Signature of Funeral Service Licensee: ▶ R. N. Horton
22. Name end Address of Fecility: R.N. Horton Co. Morticians, Inc. 600 Kennedy St., NW Washington, DC 20011

Physician /Medical Examiner

23a. Pert1. Enter the disaesa, or complications that caused tha daath. Do not antar tha mode of dying, such as cardiac or raspiratory arrest, shock, or heert feilure. List only one ceuse on each line. — Approximata Intervel Between Onsat end Death

Immediate Ceuse (Finel diseese or condition resulting in death): e. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE
Due to (or es a consequence of):
Sequentially list conditions, If eny, leeding to Immediate ceuse. Enter Underlying Ceuse (Disease or injury thet Initieted events resulting in deeth) Lest:
b. Due to (or es a consequence of):
c. Due to (or es e consequence of):
d.

Part II. **Othar significant conditione** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. **Did tobecco use contributa to the cauee of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings aveilable prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☒ Yes 2☐ No
26. Piece of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☒ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*
27. Manner of Deeth: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, streat, fectory, office building, etc. *(Specify)*
28f. Location *(Streat end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician**: To the best of my knowledge, death occurred et the time, date end piece, end due to the ceuse(s) end menner es steted. 2☒ **Medical Examiner**: On the basis of examination end/or investigation, In my opinion, death occurred et the time, date end piece, end due to the ceuse(s) end menner stated.
29b. Signature end title of certifier: ▶ [signature] MD
29c. License number: D33159
29d. Date signed *(Month, Dey, Yeer)*: NOVEMBER 12, 1998
30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): MARIO F GOLIA JR MD 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 17 1998
32. Registrar's Signatura: [signature] G. Sparks

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Peges 1 end 2 should be filed within 72 hours after death with the Marylend Department of Health end Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28e-i show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

4

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend #20b, 11/20/98, BMW, Montg.Co.

Certificate of Death

Reg. No. 98 37327

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Bonnie Jean Steller	November 14, 1998	11:50 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
615 Warfield Drive	Rockville	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
302-20-2145	1☐ M 2☒ F	69 Yrs.			December 17, 1928	Ohio

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	615 Warfield Drive	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
615 Warfield Drive	20850	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	5+	Statistician	Federal Government

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Harry Clark	Daisy Pettit

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Paula R. Knepper/Friend	615 Warfield Drive, Rockville, Maryland 20850

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Montgomery Crematorium, Inc	November 19, 1998	Bethesda, Maryland

21. Signature of Funeral Service Licensee		22. Name and Address of Facility
Michael E. Hagen	M00846	Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Myocardial Infarction	1 hour
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Atrial Fibrillation

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☑ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☑ Yes 2☐ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Robert L. Gold MD	29300	November 16, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert L. Gold, M.D., 15225 Shady Grove Road #201, Rockville, Maryland 20850-3259

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 17 1998	Geneva G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 96 37320

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Charles I. Sheetz

2. Date of Death Month Day Year: November 13, 1998

3. Time of Death: 1656

4e. Facility Name *(If not institution, give street and number)*: Montgomery General Hospital

4b. City, Town, or Location of Death: Olney

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-42-2763

6. Sex: 1☒M 2☐F

7. Age *(In yrs. last birthday)*: 70 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Feb. 9, 1928

9. Birthplace *(State or Foreign Country)*: Washington, DC

Usual Residence of Decedent

10a. State: MD

10b. County: Montgomery

10c. City, Town or Location: Kensington

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 10606 Brunswick Avenue

10f. Zip Code: 20895

10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) | College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Civil Engineer

16b. Kind of Business/Industry: Washington Suburban Sanitary Commission

17. Father's Name *(First, Middle, Last)*: Charles E. Sheetz

18. Mother's Name *(First, Middle, Maiden Surname)*: Margaret Ann Parker

19a. Informant's Name/Relationship *(Type, Print)*: Margaret Ann Sheetz (wife)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 10606 Brunswick Avenue, Kensington, MD 20895

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Parklawn Memorial Park | Date: 11/18/98

20c. Location - City or Town, State: Rockville, MD

21. Signature of Funeral Service Licensee: James E Dooley

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Acute Myocardial Infarction

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day Year)* | 28b. Time of Injury | 28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: James P. Asher MD

29c. License number: D34032

29d. Date signed *(Month, Day, Year)*: 11/14/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JEANNE P. ASHER, MD 3720 FARRAGUT AVE KENSINGTON, MD 20895

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 17 1998

32. Registrar's Signature: Jennie G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37329

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Harold B.A. Sheppard
2. Dete of Death Month Dey Yeer: November 18, 1998
3. Time of Death: 10:50 AM
4a Feclity Neme *(If not institution, give street end number)*: Washington Adventist Hospital
4b. City, Town, or Location of Death: Takoma Park
4c. County of Deeth: Montgomery

Funeral Director

5. Sociel Security Number: 578-64-9302
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. lest birthday)*: 55 Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Dey, Yeer)*: April 25,1943
9. Birthplece *(State or Foreign Country)*: Guyana

Usual Residence ot Decedent

10e. Stete: MD
10b. County: Prince Georges
10c. City, Town or Location: Hyattsville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 2508 Van Buren Street
10f. Zip Code: 20782
10g. Citizen of Whet Country?: USA

11. Maritel Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Detes:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indien, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12); College (1-4or 5+): 4
16e. Decedent's Usual Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Manager
16b. Kind ot Business/Industry: Law Firm

17. Father's Neme *(First, Middle, Last)*: William A. Sheppard
18. Mother's Neme *(First, Middle, Melden Surneme)*: Agnes Swain

19a. Intorment's Neme/Reletionship *(Type, Pnint)*: Gwendolyn A. Sheppard (wife)
19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 2508 Van Buren Street, Hyattsville, MD 20782

20a. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removel trom Stete 4☐ Donetion 5☐ Other *(Specify)*
20b. Place of Disposition *(Neme of cemetery, cremetory or other place)*: Metropolitan Crematory
Dete: 11/21/98
20c. Location - City or Town, Stete: Alexandria, Virginia

21. Signature of Funeral Service Licensee: L. Kevin Gutowski
22. Neme end Address of Fecility: Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Death

Immediate Ceuse (Final diseese or condition resulting in deeth):
e. MASSIVE GASTROINTESTINAL BLEEDING — 10 HRS
Due to (or es e consequence ot):
b. METASTATIC GASTRIC CANCER — 7 months
Due to (or as e consequence of):
c. MALIGNANT GASTRIC ULCER
Due to (or es e consequence ot):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury thet initieted events resulting in deeth) Lest

Pert tt. **Other significant conditione** contributing to deeth but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Wes en autopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings available prior to completion ot cause of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Deeth *(Check only one)*: Hospitel: 1☒ Inpetient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28e. Dete of Injury *(Month, Dey Yeer)*
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, term, street, tactory, office building, etc. *(Specify)*
28t. Location *(Street and Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best ot my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner es steted. 2☐ **Medtcal Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) end menner steted.

29b. Signature end title of certifier: [illegible] MD
29c. License number: D 19971
29d. Dete signed *(Month, Dey, Yeer)*: 11/18/98

30. Neme end eddress of person who completed cause ot death (Item 23e) (Type, Print): K. SUD HAKAR, MD. 7610 CARROLL AVE #230, TAKOMA PARK MD 20912

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: NOV 20 1998
32. Registrer's Signeture: Geneva G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

2+1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 07330

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARIETTA GLEZOS SHETLER

2. Date of Death Month Day Year: NOVEMBER 16, 1998

3. Time of Death: 6:50 AM

4a. Facility Name *(If not institution, give street and number)*: HOLY CROSS HOSPITAL

4b. City, Town, or Location of Death: SILVER SPRING

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 579-18-2021

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 77 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Yaar)*: SEPT. 9, 1921

9. Birthplaca *(Stata or Foreign Country)*: CANADA

Usual Rasidance of Decedant

10a. Stata: MD

10b. County: MONTGOMERY

10c. City, Town or Location: WHEATON

10d. Insida City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 10820 GEORGIA AVE. APT 207

10f. Zip Coda: 20902

10g. Citizan of What Country?: USA

11. Marital Status: 1☐ Navar Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedant Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yes, Give Yaar or Datas:

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specity Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No *Specify:*

14. Race - Amarican Indian, Black, White, atc. *Specify:* WHITE

15. Decedent's Education *(Spacify only highast grada completed)*: Elementary/Secondary (0-12): 9 / College (1-4or 5+):

16a. Dacedant's Usual Occupation *(Giva kind of work dona during most of working life. DO NOT use retired)*: HOME MAKER

16b. Kind of Business/Industry: OWN HOME

17. Fathar's Nama *(First, Middla, Last)*: EMMANUEL J. GLEZOS

18. Mothar's Nama *(First, Middla, Maidan Sumama)*: SOPHIA KATSOUROS

19a. Informant's Name/Ralationship *(Type, Print)*: DOROTHY GLEZOS (SISTER)

19b. Mailing Addrass *(Straet and Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: 10820 GEORGIA AVE. APT. 109 WHEATON, MD 20902

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Spacify)*

20b. Placa of Disposition *(Nama of cematary, cramatory or othar place)*: PARK LAWN MEMORIAL PARK

Data: 11-18-98

20c. Location - City or Town, Stata: ROCKVILLE, MD

21. Signatura of Funeral Service Licensee: David F. Mc[illegible]

22. Nama and Address of Facility: HINES-RINALDI 11800 NEW HAMPSHIRE AVE. SILVER SPRING, MD 20904

Brw

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only ona causa on aach lina.

Approximata Intarval Between Onsat and Death: one week

Immadiata Cause (Final disaasa or condition rasulting in daath)

a. Sepsis

Dua to (or as a consequance of):

Sequentially list conditions, if any, laading to immadiata ceusa. Entar Undarlying Causa (Disaasa or injury that initiated avants rasulting in daath) Last

b. Ischemic lower extremity

Dua to (or as a consequance of):

c. peripheral vascular disease

Dua to (or as a consequance of):

d.

Part II. **Othar significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.

23b. Did tobacco usa contributa to the causa of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings availabia prior to complation of ceusa of deeth? 1☐ Yas 2☐ No

25. Was cesa rafarrad to medical examinar? 1☐ Yas 2☒ No

26. Placa of Daath *(Check only one)*: Hospital: 1☒ Inpatiant 2☐ ER/Outpatient 3☐ DOA Othar: 4☐ Nursing Homa 5☐ Rasidance 6☐ Othar *(Specify)*

27. Mannar of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be datarmined

28a. Data of Injury *(Month, Day Year)*

28b. Tima of injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28a. Placa of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Straat and Number or Rural Route Number, City or Town, Stata)*

29a. Cartifiar *(Check only one)*: 1☒ **Cartifying Physician:** To the best of my knowledge, daath occurred at the time, dete end place, end due to tha cause(s) and mannar as steted. 2☐ **Madical Examinar:** On the basis of axamination and/or investigation, in my opinion, death occurred at tha tima, data and place, end due to tha ceuse(s) and mannar statad.

29b. Signatura and title of cartifiar: [signature]

29c. Licansa number: D62578

29d. Date signed *(Month, Day, Year)*: Nov 16, 1998

30. Nama and address of person who complated ceusa of death (Itam 23a) (Type, Print): Gail CHAIKEN, 11119 Rockville Pike #216, Rockville MD 20852

State Registrar

31. Data filed *(Month, Day, Year)*: NOV 18 1998

32. Registrar's Signatura: D. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37331

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Hye Sik Sim

2. Date of Death (Month, Day, Year): November 16, 1998

3. Time of Death: 3:30 PM

4a. Facility Name (If not institution, give street and number): Mariner Health of Bethesda

4b. City, Town, or Location of Death: Bethesda

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 223-96-4313

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 81 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): April 9, 1917

9. Birthplace (State or Foreign Country): Korea

Usual Residence of Decedent

10a. State: MD

10b. County: Montgomery

10c. City, Town or Location: Bethesda

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 5721 Grosvenor Lane

10f. Zip Code: 20814

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Asian

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Young Chin Min

18. Mother's Name (First, Middle, Maiden Surname): Chung Won Pyun

19a. Informant's Name/Relationship (Type, Print): Chung Lim Sim (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1412 Casino Circle, Silver Spring, MD 20906

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Parklawn Memorial Park

Date: 11/18/98

20c. Location - City or Town, State: Rockville, MD

21. Signature of Funeral Service Licensee: Scott L. Smith

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Pneumonia — Due to (or as a consequence of): — days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. — Due to (or as a consequence of):

c. — Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

congestive heart failing

Parkinson's disease

hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: David A. Blass MD

29c. License number: 023911

29d. Data signed (Month, Day, Year): November 17, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David A. Blass MD 9410 Old Georgetown Road Bethesda, Md. 20814

State Registrar

31. Data filed (Month, Day, Year): NOV 18 1998

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Dmd

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Genevieve Mary LeCarpenter SMITH
Baltimore, Maryland 21215-0020

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Genevieve Le Carpentier Smith
2. Date of Death Month Day Yeer: November 15, 1998
3. Tima of Deeth: 3:02 AM
4a. Facility Name *(If not institution, give street and number)*: Doctors Community Hospital
4b. City, Town, or Location of Death: Lanham
4c. County of Deeth: Prince Georges

Funeral Director

5. Social Security Numbar: 577-01-4611
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 79 Yrs. — If Undar 1 Yaar: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: May 20, 1919
9. Birthpleca *(Stata or Foreign Country)*: New Jersey

Usual Residence of Decedent

10a. Stete: MD
10b. County: Prince Georges
10c. City, Town or Location: College Park
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 9300 48th Place
10f. Zip Code: 20740
10g. Citizen of Whet Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedant Evar in U.S. Armed Forces?: 1☐ Yas 2☒ No — If Yes, Give Yeer or Detas:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puerto Rican, atc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indien, Bleck, Whita, atc. *Specify:* White

15. Decedent's Education *(Specify only highest greda completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16e. Decedent's Usual Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Accountant
16b. Kind of Business/Industry: State Government

17. Fathar's Neme *(First, Middle, Last)*: George Le Carpentier
18. Mother's Nema *(First, Middle, Meiden Surneme)*: Ethel Rice

19e. Informent's Neme/Reletionship *(Type, Print)*: Claude E. Smith (husband)
19b. Meiling Address *(Street end Number or Rural Routa Numbar, City or Town, Steta, Zip Code)*: 9300 48th Place, College Park, MD 20740

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Piece of Disposition *(Name of cemetery, crematory or other place)*: Gate of Heaven Cemetery
Date: 11/18/98
20c. Location - City or Town, State: Washington, DC

21. Signature of Funeral Service Licensee: Scott L. Smith
22. Name end Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions that caused tha daath. Do not anter the moda of dying, such as cardiac or respiretory errest, shock, or heert failure. List only one ceuse on each line.

Approximete Intervel Between Onset end Death

Immediete Ceuse (Final disaasa or condition resulting in death)
e. ACUTE ATRIAL FIBRILLATION — 11-1098.
Due to (or es e consequence of):
b. SEPSIS DUE TO DECUBITUS ULCER — 11-1-98
Sequentially list conditions, if eny, laeding to immediate cause. Enter Underlying Cause (Diseese or Injury thet initieted events resulting in death) Lest
Dua to (or as a consequance of):
c. CHRONIC OBSTRUCTIVE PULMONARY DISEASE — 1-192
Dua to (or as a consequance of):
d. CARDIOGENIC SHOCK.

Part II. **Other eignficent conditions** contributing to death but not resulting in the underlying cause given in Part I.: SECONDARY RENAL FAILURE

23b. Did tobacco uee contribute to the cauee of death?: 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed?: 1☐ Yes 2☒ No
24b. Were eutopsy findings eveileble prior to completion of cause of death?: 1☐ Yes 2☐ No

25. Was case referred to medical examiner?: 1☐ Yas 2☒ No

26. Placa of Deeth *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpetiant 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Deeth: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury et Work?: 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, fectory, offica building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) and menner es steted. 2☐ **Medical Examiner**: On the besis of examination end/or Investigetion, In my opinion, death occurred et the time, date end place, end due to the ceuse(s) and menner steted.

29b. Signature and title of certifier: A. Hussain MD.
29c. License number: D0013668
29d. Date signed *(Month, Day, Year)*: 11-16-98

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print): AZHER HUSSAIN. MD 4917, EDGEWOOD RD. COLLEGE PK. MD. 2c740

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 17 1998
32. Registrer's Signetura: Donna B. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: CHARLES O. SHOEMAKER SR.

2. Data of Death Month Day Year: NOVEMBER 14,1998

3. Time of Death: 11:40 AM

4a. Facility Name *(If not institution, give street and number)*: MONTGOMERY VILLAGE CARE AND REHABILITATION

4b. City, Town, or Location of Death: MONTGOMERY VILLAGE

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 579 07 2708

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 82 Yrs.

If Under 1 Yaer: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Yeer)*: OCT. 21,1916

9. Birthplace *(Stete or Foreign Country)*: MARYLAND

Usuel Residence of Decedant

10e. State: MD.

10b. County: MONTGOMERY

10c. City, Town or Location: CLARKSBURG

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Streat and Number: 23800 RIDGE ROAD

10f. Zip Code: 20871

10g. Citizen of Whet Country?: UNITED STATES

11. Maritel Stetus: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Yaar or Detes: WW II

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:

14. Rece - American Indien, Bleck, White, etc. Specify: WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12): 7 College (1-4or 5+): 0

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: PHYSICAL SCIENCE TECHNICIAN

16b. Kind of Business/Industry: U.S. GOVERNMENT

17. Fether's Neme *(First, Middle, Last)*: CHARLES ROGER SHOEMAKER

18. Mother's Name *(First, Middle, Meiden Surneme)*: VIRGINIA WILT

19e. Informent's Name/Reletionship *(Type, Print)*: PATRICK L. SHOEMAKER, SON

19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 7513 CAMP ALGER AVENUE, FALLS CHURCH, VA. 22042

20e. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Ramoval from State 4 [ ] Donetion 5 [ ] Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: LAYTONSVILLE CEMETERY

Date: 11/18/98

20c. Location - City or Town, Stete: LAYTONSVILLE, MD.

21. Signetura of Funeral Service Licensee: Muriel H. Barber

22. Neme end Address of Fecility: MURIEL H. BARBER FUNERAL HOME P.O. BOX 5038, LAYTONSVILLE, MD. 20882

Physician /Medical Examiner

23a. Part1. Enter the disaasa/or complications that caused tha death. Do not antar the moda of dying, such as cardiac or raspiratory arrest, shock, or heert failure. List only one ceuse on eech line.

Approximate Intervel Between Onset end Death

Immediete Cause (Finel disaase or condition resulting in death): e. Emphysema — 3yrs

Due to (or es e consequenca of):

Sequentially list conditions, if any, leeding to immediata cause. Enter Underlying Cause (Diseese or Injury thet initieted events resulting in death) Last:

b. Tobacco smoking — 50yrs

Due to (or as a consequance of):

c.

Due to (or es e consequance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: cor pulmonale, gastrointestinal bleeding

23b. **Did tobacco use contribute to the cause of death?** 1 [X] **Yes** 2 [ ] **No** 3 [ ] **Probably** 4 [ ] **Unknown**

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were eutopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Wes case referred to medical exeminer? 1 [ ] Yes 2 [X] No

26. Plece of Death *(Check only one)*: Hospitel: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Menner of Deeth: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicida 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Dete of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28a. Place of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at tha time, date and plece, end due to the cause(s) and menner as steted. 2 [ ] **Medical Examiner:** On tha basis of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, date end piece, end due to the cause(s) end menner steted.

29b. Signetura and title of certifier: A. Pollack MD

29c. Licanse number: D33443

29d. Date signed *(Month, Day, Year)*: November 16, 1998

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): Alan R. Pollack, M.D. 809 Viers Mill Rd. Rockville, Md 20851

State Registrar

31. Dete filed *(Month, Day, Year)*: NOV 17 1998

32. Registrer's Signeture: G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Deperiment of Health and Mantel Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37334

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOHNNY A. SMITH
2. Dete of Deeth: Month 11 - Dey 15 - Yeer 98
3. Time of Death: 1:58AM
4e. Feciity Neme (If not institution, give street end number): UNIVERSITY of MARYLAND MEDICAL CENTER
4b. City, Town, or Location of Deeth: BALTIMORE
4c. County of Deeth: Baltimore City

Funeral Director

5. Social Security Number: 249-60-5261
6. Sex: XX M 2☐ F
7. Age (In yrs. lest birthday): 60 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Yeer): June 28, 1938
9. Birthplece (State or Foreign Country): South Carolina

Usual Residence of Decedent

10a. Stete: Maryland
10b. County: Prince George's
10c. City, Town or Location: Beltsville
10d. Inside City Limits: 1☐ Yes XX No
10e. Street end Number: 10503 Weymouth Avenue
10f. Zip Code: 20705
10g. Citizen of Whet Country?: United States

11. Marital Status: 1☐ Never Married 2XX Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? XX Yes 2☐ No If Yes, Give Year or Dates: 1955-1959
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐ Yes XX No Specify:
14. Race - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Edcetion (Specify only highest grede completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): General Foreman
16b. Kind of Business/Industry: U.S. Capital Power Plant

17. Fether's Neme (First, Middle, Last): Vincent Arrigo
18. Mother's Name (First, Middle, Maiden Surname): Elizabeth Parker

19e. Informent's Name/Relationship (Type, Print): Mary Ann Smith (wife)
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): same as #10

20e. Method of Disposition: 1XX Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Gate of Heaven Cemetery
Date: 11/18/1998
20c. Location - City or Town, State: Silver Spring, Maryland

21. Signature of Funeral Service Licensee: Donald V. Borgwardt
22. Name end Address of Feciity: Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert failure. List only one cause on eech line.

		Approximete Interval Between Onset end Death
Immediate Ceuse (Finel disease or condition resulting in deeth) e.	Acidosis	4hr
Due to (or es e consequence of):		
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury thet initiated events resulting in deeth) Last: b.	Sepsis	3 days
Due to (or es e consequence of):		
c.		
Due to (or es e consequence of):		
d.		

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobecco uee contribute to the cauee of deeth? 1☐ Yee 2☒ No 3☐ Probebly 4☐ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? 1☐ Yes 2☒ No

25. Was case referred to medical exeminer? 1☐ Yes 2☒ No

26. Piece of Deeth (Check only one): Hospital: 1☒ Inpetient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Yeer)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physicien:** To the best of my knowledge, deeth occurred et the time, date end piece, and due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the besis of exemineticn end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) and menner stated.

29b. Signeture end title of certifier
29c. License number: P11748
29d. Date signed (Month, Day, Year): 11/15/98

30. Neme end address of person who completed cause of death (Item 23e) (Type, Print): Kester Crosse 22 S. Greene St Baltimore, MD 21201

State Registrar

31. Dete filed (Month, Day, Year): NOV 17 1998
32. Registrer's Signature: G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funerel director, page 2 should be detached for use es the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37335

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Leo O. Sobel

2. Date of Death Month Day Year: November 11, 1998

3. Time of Death: 3:10 PM

4a. Facility Name *(If not institution, give street and number)*: Hillhaven Nursing Center, Inc.

4b. City, Town, or Location of Death: Adelphi

4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 579-16-3178

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 99 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: Sep. 1, 1899

9. Birthplace *(State or Foreign Country)*: New York

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 8202 New Hampshire Avenue

10f. Zip Code: 20903

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Salesman

16b. Kind of Businass/Industry: Jewelry

17. Father's Nama *(First, Middle, Last)*: Isidor Sobel

18. Mother's Nama *(First, Middle, Maiden Surname)*: Susanna Lehman

19a. Informant's Name/Relationship *(Type, Print)*: Ronetta H. Knoblett (friend)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 13112 Taney Drive Beltsville,Maryland 20705

20a. Method of Disposition: 1 ☒ Buriat 2 ☐ Cremetion 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Fort Lincoln Cemetery | Data: 11/14/98

20c. Location - City or Town, Stata: Brentwood,Maryland

21. Signature of Funeral Service Licensee: ▶ Eric S. Scerbo

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd.,W.,Silver Spring,MD 20901

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

BAW

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximata Intarval Batween Onsat and Death

Immediate Cause (Final disease or condition resulting in death): a. Cardiac Arrest

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Congestive Heart Failure

Due to (or as a consequence of):

c. Renal Failure

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributa to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Wara autopsy findings availabla prior to complation of causa of death? 1 ☐ Yas 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Othar *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Data of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and dua to tha cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Lisa Lilienfield, MD

29c. License number: D 28977

29d. Data signed *(Month, Day, Year)*: November 13, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Lisa Lilienfield, M.D. 7676 New Hampshire Avenue #215 Langley Park,MD 20783

State Registrar

31. Data filed *(Month, Day, Year)*: NOV 16 1998

32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37336

Physician /Medical Examiner

1. Decedent's Nama *(First, Middle, Last)*: ELLEN W. STANKOVICH
2. Data of Death Month Day Yaar: November 13, 1998
3. Time of Death: 1508

4a Facility Nama *(If not institution, give street and number)*: Suburban Hospital
4b. City, Town, or Location of Daath: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Sacurity Number: 119-24-7033
6. Sex: 1☐ M 2☒ F
7. Aga *(In yrs. last birthday)*: 76 Yrs.
If Under 1 Yaar: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Yaar)*: March 13, 1922
9. Birthplace *(Stata or Foreign Country)*: Germany

Usual Rasidance of Dacedant

10a. Stata: Maryland
10b. County: Montgomery
10c. City, Town or Location: Bethesda
10d. Insida City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 8315 North Brook Lane #401
10f. Zip Coda: 20814
10g. Citizan of What Country?: United States

11. Marital Status: 1☐ Nevar Married 2☒ Married 3☐ Widowad 4☐ Divorcad
12. Was Dacedent Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:
13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yas 2☒ No *Specify:*
14. Race - Amarican Indian, Black, Whita, atc. *Specify:* White

15. Decedent's Education *(Specify only highast grada complatad)*: Elamantary/Secondary (0-12); College (1-4or 5+): 5
16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa retirad)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Fathar's Name *(First, Middla, Last)*: Walter Sander
18. Mother's Nama *(First, Middla, Maidan Surname)*: Elfriede (Not Available)

19a. Informant's Name/Ralationship *(Type, Print)*: Arthur S. Stankovich/Husband
19b. Mailing Addrass *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: 8315 North Brook Lane #401, Bethesda, Maryland 20814

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*
20b. Place of Disposition *(Nama of cametary, cramatory or othar place)*: Gate of Heaven Cemetery
Data: November 16, 1998
20c. Location - City or Town, Stata: Silver Spring, Maryland

21. Signature of Funaral Sarvica Licansaa: Michael E. Hagens M00846
22. Nama and Addrass of Facility: Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that causad tha daath. Do not antar the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on each lina. — Approximata Interval Batween Onset and Death

Immediata Cause (Final disaase or condition resulting in death)
a. RESPIRATORY FAILURE
Dua to (or as a consequanca of):
b. HEMORRHAGIC STROKE

Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or injury that initiatad avants rasulting in daath) Last
Dua to (or as a consaquance of):
c.
Dua to (or as a consequanca of):
d.

Part II. **Othar significant conditions** contributing to death but not rasulting in tha undarlying causa given in Part I.

23b. **Did tobacco usa contribute to the cause of death?** 1☒ **Yes** 2☐ **No** 3☐ **Probably** 4☐ **Unknown**

24a. Was an autopsy performad? 1☐ Yas 2☒ No
24b. Ware autopsy findings available prior to complation of cause of death? 1☐ Yas 2☐ No

25. Was casa rafarrad to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only ona)*: Hospital: 1☒ Inpatiant 2☐ ER/Outpatient 3☐ DOA; Othar: 4☐ Nursing Homa 5☐ Residence 6☐ Othar *(Specify)*

27. Mannar of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Yaar)*
28b. Tima of Injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurred
28e. Placa of Injury - At homa, farm, straat, factory, office building, atc. *(Specify)*
28f. Location *(Straat and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifiar *(Check only one)*: 1☒ **Certifying Physician:** To tha bast of my knowladga, death occurred at tha tima, data and place, and dua to tha ceuse(s) and mannar as steted. 2☐ **Medical Examiner:** On tha basis of examination and/or investigation, in my opinion, daath occurred at tha tima, data and placa, and dua to tha causa(s) and manner stated.

29b. Signature and Title of Certifier: Irving Mizus
29c. Licansa number: D26571
29d. Data signed *(Month, Day, Yaar)*: 11/13/98

30. Nama and addrass of person who completed cause of daath (Item 23a) (Type, Print): Irving Mizus, M.D., 5413 Cedar Lane #206 C, Bethesda, Maryland 20814

State Registrar

31. Data filad *(Month, Day, Yaar)*: NOV 16 1998
32. Registrar's Signatura: Jennie G. Sparks

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

ELLEN STANKOVICH 11-13-98/1508PM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37337

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Francis P. Sorbo Sr.

2. Dete of Deeth — Month: November — Day: 6 — Year: 1998

3. Time of Death: 8:00 pm

4a. Fecility Neme *(If not institution, give street and number)*: 2818 Greenway Drive

4b. City, Town, or Location of Deeth: Ellicott City

4c. County of Death: Howard

Funeral Director

5. Social Security Number: 131-14-1046

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 73 Yrs. — If Under 1 Yeer: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Dey, Yeer)*: Feb 15, 1925

9. Birthplece *(Stete or Foreign Country)*: New Jersey

Usual Residence of Decedent

10e. State: Maryland — 10b. County: Howard — 10c. City, Town or Location: Ellicott City — 10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street end Number: 2818 Greenway Drive — 10f. Zip Code: 21042 — 10g. Citizen of Whet Country?: United States

11. Meritel Status: 1 [ ] Never Married 2 [ ] Merried 3 [X] Widowed 4 [ ] Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Rece - American Indien, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grede completed)*: Elementery/Secondery (0-12) — College (1-4or 5+): 2

16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Assistant Vice President

16b. Kind of Business/Industry: Banking

17. Fether's Name *(First, Middle, Last)*: Elpidio Sorbo

18. Mother's Name *(First, Middle, Maiden Surneme)*: Rose Girardi

19e. Informant's Name/Relationship *(Type, Print)*: Frank Sorbo, Jr./Son

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 10261 Wetherburn Road Ellicott City, MD 21042

20e. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removel from State 4 [ ] Donetion 5 [ ] Other *(Specify)*

20b. Pleca of Disposition *(Neme of cemetery, cremetory or other piece)*: Cheltenham Veterans Cem. — Dete: 11-12-98 — 20c. Location - City or Town, State: Cheltenham, MD

21. Signature of Funerel Service Licensee: ▶ Sherri A. Collins-Witzke

22. Neme end Address of Facility: Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043

Physician /Medical Examiner

23a. Pert I. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Ceuse (Finel diseese or condition resulting in death) a. CHRONIC OBSTRUCTIVE PULMONARY DISEASE — Several YEARS

Due to (or es a consequence of):

Sequentielly list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Disease or Injury thet Initieted events resulting in death) Lest

b. —

Due to (or as e consequence of):

c. —

Due to (or es e consequence of):

d. —

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobecco use contribute to the cause of death?** 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings eveilable prior to completion of cause of deeth? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Deeth: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)* — 28b. Time of Injury — M — 28c. Injury et Work? 1 [ ] Yes 2 [ ] No — 28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)* — 28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physicien:** To the best of my knowledge, death occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted. 2 [ ] **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end placa, and due to the cause(s) end menner stated.

29b. Signeture end title of certifier: ▶ MD

29c. License number: D0018317

29d. Date signed *(Month, Day, Yeer)*: November 9, 1998

30. Neme end eddress of parson who completed cause of deeth (Item 23e) (Type, Print): BERNARD P. FARRELL MD 11055 LITTLE PATUXENT PARKWAY, COLUMBIA, MD 21044

State Registrar

31. Date filed *(Month, Dey, Yeer)*: NOV 10 1998

32. Registrer's Signeture: Geneva G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

8 Vet

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98C 37338

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
Dorothy	Juanita	Sanford	November 18 1998	5:18 pm

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
3012 Peebles Court	Olney	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-38-4090	1☐ M 2☒ F	87 Yrs.			Oct 30, 1911	Kansas

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Olney	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3012 Peebles Court	20832	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4 or 5+)		
Grade 8		Secretary	National Weather Ser.

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
John Mickens	Elizabeth Haynes

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Dorothy Dell Vermillion/daughter	8286 Mary Lee Lane Laurel, Maryland 20723

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Ft. Lincoln Cemetery	Nov. 21, 1998	Brentwood, Md.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Guy S. Kopp	Donaldson Funeral Home, P.A. 313 Talbott Avenue Laurel, Maryland 20707

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Colon cancer	8 months
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☒ Residence 8☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature]	D45880	11/19/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
10400 Connecticut Avenue Suite 606 Kensington, Maryland 20895

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 19 1998	▶ Geneva G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37339

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mildred Betty Schmidt
2. Date of Death (Month, Day, Year): November 18, 1998
3. Time of Death: 2:15 AM
4a. Facility Name (If not institution, give street and number): Magnolia Gardens Nursing Home
4b. City, Town, or Location of Death: Lanham
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 579 26 4108
6. Sex: 1☐ M 2☐ F XX
7. Age (In yrs. last birthday): 72 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan 1, 1926
9. Birthplace (State or Foreign Country): Washington DC

Usual Residence of Decedent

10e. State: MD
10b. County: P.G.
10c. City, Town or Location: Upper Marlboro
10d. Inside City Limits: 1☐ Yes 2☐ No XX
10e. Street and Number: 9106 Dandelion Lane
10f. Zip Code: 20772
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed XX 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Service Rep.
16b. Kind of Business/Industry: Bell Atlantic

17. Father's Name (First, Middle, Last): Robert Lamberson
18. Mother's Name (First, Middle, Maiden Surname): Mary Roney

19a. Informant's Name/Relationship (Type, Print): Kerry Keister (SON)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9106 Dandelion Lane, Upper Marlboro, Maryland 20772

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or other place): Lee Crematory Nov 18, 1998
Date:
20c. Location - City or Town, State: Clinton,Maryland

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: Lee Funeral Home,Inc 6633 Old Alexandria Ferry Road, Clinton,Maryland 20735

Physician Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on eech line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) e.	LEFT HEART FAILURE	3 MOS
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest b.	ARTERIOSCLEROTIC HEART DISEASE	1 YR
Due to (or as a consequence of):		
c.		
Due to (or as e consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause givan in Part I.: POST CEREBRAL VASCULAR THROMBOSIS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Yaar)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Phyaician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Rodger B. Ingham
29c. License number: D05891
29d. Date signed (Month, Dey, Year): 11-18-98

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Rodger B. Ingham, M.D. 6510 Kenilworth Ave, #2400 Riverdale, Md 20737

State Registrar

31. Date filed (Month, Day, Year): NOV 25 1998
32. Registrar's Signature: ▶ Donna G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Robert Glen Smoot, Sr.

2. Dete of Deeth — Month: Nov. Dey: 20, Year: 1998

3. Time of Death: 7:50 P.M.

4e. Feclity Neme *(If not institution, give street and number)*: 511 Laurel Drive

4b. City, Town, or Location of Deeth: Lusby

4c. County of Deeth: Calvert

Funeral Director

5. Social Security Number: 235-42-8860

6. Sex: 1☒M 2☐F

7. Age *(In yrs. last birthday)*: 70 Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Dey, Year)*: June 21, 1928

9. Birthplace *(Stete or Foreign Country)*: West Virginia

Usuel Residence of Decedent

10a. Stete: Maryland

10b. County: Calvert

10c. City, Town or Location: Lusby

10d. Inside City Limits: 1☐Yes 2☒No X

10e. Street end Number: 511 Laurel Drive

10f. Zip Code: 20657

10g. Citizen of Whet Country?: United States

11. Mertel Stetus: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐Yes 2☒No *Specify:*

14. Rece - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grede completed)*: Elementery/Secondery (0-12): 8th — College (1-4or 5+):

16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Construction

16b. Kind of Business/Industry: Storm & Sewage Drains

17. Fether's Neme *(First, Middle, Last)*: William Thomas Smoot

18. Mother's Neme *(First, Middle, Maiden Surneme)*: Orpha C. Nutter

19e. Informent's Neme/Reletionship *(Type, Print)*: Frances J. Smoot (wife)

19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 511 Laurel Drive, Lusby, Maryland 20657

20e. Method of Disposition: 1☒Buriel 2☐Cremetion 3☐Removel from Stete 4☐Donetion 5☐Other *(Specify)*

20b. Plece of Disposition *(Neme of cemetery, crematory or other piece)*: MD Veterans Cemetery Nov — Date: 25, 98

20c. Location - City or Town, Stete: Cheltenham, Maryland

21. Signeture of Funerel Service Licensee: ▶ St. E. Sitt

22. Neme end Address of Feclity: Lee Funeral Home, Calvert, P.A. 8125 Southern MD Blvd; Owings, MD 20736

Physicien /Medical Examiner

23a. Pert1. Enter the disease, or complicetions thet caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert feilure. List only one cause on eech line.

Approximete Intervel Between Onset end Deeth

Immediete Ceuse (Finel diseese or condition resulting in deeth): e. Cancer of the lung with liver metastasis

Due to (or es e consequence of):

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Diseese or Injury thet Initieted events resulting in death) Lest:

b. Hypertension

Due to (or as a consequence of):

c.

Due to (or es e consequenca of):

d.

Pert II. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Pert I.

23b. **Did tobacco use contribute to the cause of death?** 1☐**Yes** 2☐**No** 3☐**Probably** 4☑**Unknown**

24e. Wes en eutopsy performed? 1☐Yes 2☑No

24b. Were eutopsy findings eveileble prior to completion of cause of death? 1☐Yes 2☐No

25. Wes case referred to medical exeminer? 1☐Yes 2☑No

26. Place of Deeth *(Check only one)*: Hospitel: 1☐Inpetient 2☐ER/Outpetient 3☐DOA — Other: 4☐Nursing Home 5☑Residence 6☐Other *(Specify)*

27. Menner of Deeth: 1☑Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigation 6☐Could not be determined

28e. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1☑**Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner es steted. 2☐**Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner steted.

29b. Signeture and title of certifier: ▶

29c. License number: D14760

29d. Dete signed *(Month, Dey, Year)*: November 23, 1998

30. Neme end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print): STEPHEN ONG, M.D. 6357 OXON HILL RD, OXON HILL, MD 20745

8+1

State Registrar

31. Dete filed *(Month, Dey, Year)*: NOV 24 1998

32. Registrer's Signeture: ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Helen Elizabeth States

2. Date of Death (Month, Day, Year): October 19, 1998

3. Time of Death: 7:10a.m.

4a. Facility Name *(If not institution, give street and number)*: 9956 Flatland Road (Residence)

4b. City, Town, or Location of Death: Chestertown

4c. County of Death: Kent

Funeral Director

5. Social Security Number: 220-24-8126

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 70 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Aug. 30, 1928

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Kent

10c. City, Town or Location: Chestertown

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 9956 Flatland road

10f. Zip Code: 21620

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 6 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Health Care Assistant

16b. Kind of Business/Industry: Nursing Homes

17. Father's Name *(First, Middle, Last)*: John Emory Beck

18. Mother's Name *(First, Middle, Maiden Surname)*: Dorothy Louise Meekins

19a. Informant's Name/Relationship *(Type, Print)*: Peggy Louise States-Edwards

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 9956 Flatland Road, Chestertown, MD 21620

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Chester Cemetery

Date: 10/22/98

20c. Location - City or Town, State: Chestertown, MD

21. Signature of Funeral Service Licensee: Kirk J. Helfenbein

22. Name and Address of Facility: Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, MD 21620

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. METASTATIC COLON CANCER — 3 MOS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John C. Seymour MD

29c. License number: MD-13824

29d. Date signed *(Month, Day, Year)*: 10-21-98

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): John C. Seymour, MD 122 Speer Road, Suite 5, Chestertown, MD 21620

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 30 1998

32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 95 71342

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: LILLIAN D. TRUITT
2. Data of Death Month Day Year: Nov. 23, 1998
3. Time of Death: 10:15PM
4a. Facility Name *(If not institution, giva street and number)*: Salisbury Center; Genesis ElderCare
4b. City, Town, or Location of Death: Salisbury, Md.
4c. County of Death: Wicomico

Funeral Director

5. Social Security Number: 216-03-2702
6. Sex: 1☐M 2☒F
7. Age *(In yrs. last birthday)*: 87 Yrs. — If Under 1 Yaar: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Dey, Year)*: 4-15-11
9. Birthplace *(State or Foreign Country)*: MD

Usuel Residence of Decedant

10a. Stete: MD
10b. County: WORCESTER
10c. City, Town or Location: OCEAN CITY
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 12632 SUNSET DR.
10f. Zip Code: 21842
10g. Citizen of What Country?: USA

11. Maritel Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Was Decedent Evar in U,S. Armed Forcas? 1☐Yes 2☒No — If Yes, Give Yaer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yas 2☒No *Specify:*
14. Race - Amarican Indien, Black, White, etc. *Specify:* WHITE

15. Decedant's Educetion *(Specify only highest grada completed)*: Elementery/Secondery (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Fether's Neme *(First, Middle, Last)*: PETER ALFONSO DORSEY
18. Mother's Neme *(First, Middle, Maiden Surneme)*: ELIZABETH LANGLEY

19a. Informent's Neme/Relationship *(Type, Print)*: DORSEY TRUITT
19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 12632 SUNSET DR. OCEAN CITY, MD. 21842

20e. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from Stete 4☐Donetion 5☐Othar *(Specify)*
20b. Place of Disposition *(Nema of cemetery, cremetory or other piece)*: SALISBURY CREMATORY
Dete: 11-25
20c. Location - City or Town, State: SALISBURY, MD.

21. Signature of Fetheral Service Licensee: ▶ [signature]
22. Name and Address of Facility: ULLRICH FUNERAL HOME BERLIN, MD. 21811

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not anter the moda of dying, such as cardiac or raspiratory arrast, shock, or heart feilure. List only one ceuse on eech line.

Approximete Interval Between Onset end Death

Immediata Cause (Finel disaesa or condition resulting in death)
a. Possible Pneumonia — 10 Days

Due to (or es e consequence of):
b. Debilitated State Post Stroke

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Diseese or Injury that initieted avents resulting in death) Lest

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Recent GI Bleed 2° peptic ulcer disease

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was en eutopsy performed? 1☐Yes 2☒No

24b. Were eutopsy findings aveilable prior to completion of cause of death? 1☐Yes 2☒No

25. Wes case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA — Other: 4☒Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Menner of Death: 1☐Natural 2☐Accident 3☐Suicida 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28e. Dete of Injury *(Month, Day Year)*
28b. Time of Injury
M
28c. Injury et Work? 1☐Yes 2☐No
28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and manner es steted. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end piece, end due to the ceuse(s) and manner steted.

29b. Signeture end title of certifier: ▶ [signature]
29c. License number: D39813
29d. Data signed *(Month, Dey, Year)*: 11/24/98

30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print): MICHAEL ATKINS,M.D.,1104 HEALTHWAY DR.,SALISBURY, MD. 21804

State Registrar

31. Date filed *(Month, Dey, Year)*: NOV 25 1998
32. Registrer's Signeture: ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

6

6526-033
K.S

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

BERNARD J. TRUDELL ITEMS: #23 PART I, 27, 28A-F PER MEO G766 12-21-98

Certificate of Death

Reg. No. 98 37343

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Data of Daath Month Day Yaar	3. Tima of Death
BERNARD JOSEPH TRUDELL	NOV. 9, 1998	2157 PM

4e Facility Nama (If not institution, give street and number)	4b. City, Town, or Locafion of Daeth	4c. County of Death
PRINCE GEORGES HOSPITAL CENTER	CHEVERLY	PRINCE GEORGES

Funeral Director

5. Social Security Number	6. Sax	7. Aga (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Dete of Birth (Month, Day, Yaar)	9. Birthplace (State or Foreign Country)
008-18-3196	XM 2 F	70 Yrs.			10/27/28	VERMONT

Usual Rasidance of Decedant

10a. Sfata	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	MONTGOMERY	BETHESDA	1 Yas 2 No

10e. Street and Number	10f. Zip Coda	10g. Citizen of What Country?
5225 POOKS HILL ROAD	20814	UNITED STATES

11. Marital Status	12. Wes Decedenf Ever in U.S. Armed Forcas?	13. Was Decedanf of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexicen, Puarto Rican, atc.)	14. Race - American Indian, Black, Whita, atc.
1 Navar Married 2 Married 3 Widowed 4 Divorced	1 Yas 2 No If Yes, Give Yaar or Datas: 1951-1958	1 Yas 2 No Specify:	Specify: WHITE

15. Decedant's Education (Specify only highast grada compiatad)		16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa retired)	16b. Kind of Businass/Industry
Elementary/Secondary (0-12)	College (1-4or 5+) +4	ENGINEER	CSC / PRIVATE

17. Father's Nama (First, Middle, Last)	18. Mofher's Nama (First, Middle, Maidan Surname)
NAPOLEON TRUDELL	EVA LA RIVIERE

19a. Informanf's Name/Ralationship (Typa, Print)	19b. Mailing Addrass (Straet and Number or Rural Routa Number, City or Town, Stata, Zip Coda)
NANCY M. WHITCOMB/DAUGHTER	5376 PHELPS LUCK DRIVE, COLUMBIA, MD 21045

20a. Method of Disposition	20b. Place of Disposition (Nama of cemetery, cramatory or othar place)	Date	20c. Location - City or Town, Steta
1 Burial 2 Cremafion 3 Ramoval from Stata 4 Donafion 5 Othar (Specify)	RESURRECTION CEMETERY	11/13/98	CLINTON, MD

21. Signafura of Funaral Service Licensee: Lani E. Hollaus

22. Nama and Address of Facility: HINES-RINALDI FUNERAL HOME, 11800 NEW HAMPSHIRE AVENUE, SILVER SPRING, MARYLAND 20904

Physician /Medical Examiner

25a. Part1. Entar tha disaasa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspirafory arrast, shock, or haart failura. List only ona causa on aach lina.

		Approximafa Interval Between Onsat and Daath
Immediata Ceuse (Finel disaasa or condition resulting in death)	a. HYPERTENSIVE ATHEROSCLEROTIC CARDIOVASCULAR DISEASE COMPLICATED BY MULTIPLE INJURIES	
	Dua to (or as a consaquance of):	
Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Disaasa or Injury that initiated avants rasulting in daath) Last	b. Dua to (or as a consaquence of):	
	c. Dua to (or as e consequance of):	
	d.	

Part II. **Other significant conditfons** contributing to death but not resulting in tha undarlying ceuse given in Part I.

23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?	24b. Wara autopsy findings eveilable prior to completion of cause of death?
1 Yes 2 No	1 Yes 2 No

25. Was casa rafarrad to medical examinar?	26. Placa of Daath (Check only ona)	
Yas 2 No	Hospitel: 1 Inpafiant 2 ER/Outpetienf 3 DOA	Othar: 4 Nursing Homa 5 Residence 6 Othar (Specify)

27. Mannar of Death	28a. Data of Injury (Month, Day Yaar)	28b. Tima of Injury		28c. Injury at Work?	28d. Describa how injury occurrad
1 Natural 2 Accidant 3 Suicida 4 Homicida 5 Panding invastigation 6 Could not be determinad	11-9-98	9:45	P M	1 Yes 2 No	DRIVER IN AUTO/FIXED OBJECT COLLISION

28a. Place of Injury - At homa, farm, straat, factory, offica building, atc. (Specify)	28f. Location (Straat and Number or Rural Routa Numbar, City or Town, Stata)
STREET	3000 BLK. BLADENSBURG N.E., WASHINGTON D.C.

29a. Certifier (Check only one)

1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On tha basis of examination and/or investigation, in my opinion, death occurred at the time, dete and piece, and due to the cause(s) and mannar stated.

29b. Signature and title of certifiar	29c. Licansa number	29d. Data signed (Month, Day, Year)
Theodore M. Kling	O.C.M.E	NOV. 10, 1998

30. Nama and addrass of person who complatad cause of death (Item 23a) (Type, Print): THEODORE M. KLING, 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dafe filed (Month, Day, Year)	32. Registrar's Signatura
NOV 16 1998	Penny G. Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit ofcd.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37344

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Helen Elizabeth Thornton

2. Date of Death Month / Day / Year: November 18 1998

3. Time of Death: 8:30pm

4a. Facility Name *(If not institution, give street and number)*: Howard County General Hospital

4b. City, Town, or Location of Death: Columbia

4c. County of Death: Howard

Funeral Director

5. Social Security Number: 212-20-2855

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 73 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: July 28,1925

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Howard

10c. City, Town or Location: Ellicott City

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 5130 Bonnie Acres

10f. Zip Code: 21043

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Daniel J. McNamara

18. Mother's Name *(First, Middle, Maiden Surname)*: Helen G. Politz

19a. Informant's Name/Relationship *(Type, Print)*: Bill Thornton, Jr./Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5019 Sylvan Oaks Drive Valrico, Florida 33594

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Garrison Forest Vetr.Cem. Date: 11-25-98

20c. Location - City or Town, State: Owings Mills, MD

21. Signature of Funeral Service Licensee: Shona Collins-Witzke

22. Name and Address of Facility: Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. EMPHYSEMA.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Edward W. Schaefer MD

29c. License number: D18457

29d. Date signed *(Month, Day, Year)*: November 19, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): EDWARD W. SCHAEFER MD HOWARD COUNTY GENERAL HOSP.

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 19 1998

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4

98-6755-009
B.K.S

ERIC EDWARD THORN

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37345

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
Eric	Edward	Thorn	NOV. 17, 1998	0743 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
CALVERT MEMORIAL HOSPITAL	PRINCE FREDERICK	CALVERT

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-04-0282	1 [X] M 2 [ ] F	16 Yrs.			JUNE 15,1982	MARYLAND

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	CALVERT	CHESAPEAKE BEACH	1 [ ] Yes 2 [ ] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3251 KAREN DRIVE	20732	U. S. A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [X] Never Married 2 [ ] Merried 3 [ ] Widowed 4 [ ] Divorced	1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [ ] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondery (0-12)	College (1-4or 5+)		
11		Student	High School

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
MARK THORN	DEBORAH GRANT

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MARK THORN / FATHER	3251 KAREN DRIVE CHESAPEAKE BEACH, MARYLAND 20732

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Lee Crematory	Nov. 19, 1998	Clinton, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
[signature]	LEE FUNERAL HOME CALVERT,P.A. 8125 SOUTHERN MD BLVD. OWINGS, MARYLAND 20736

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Head and Neck Injuries	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as e consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [X] Yes 2 [ ] No	1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 [X] Yes 2 [ ] No	Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [ ] Naturel 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	Found 11/17/98	0650 HRS	1 [ ] Yes 2 [X] No	Subject driving vehicle that left the road

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
roadway	Christiana Penrose Road Chesapeake Beach Maryland

29a. Certifier (Check only one) 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
[X] **Medical Examiner:** On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
[signature]	O.C.M.E	NOV. 18, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 24 1998	[signature]

5

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

98-6756-009
B.K.S

CARA C. THORN

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98-S7346

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Data of Death Month	Day	Yaar	3. Time of Death
Cara	C.	Thorn	NOV.	17,	1998	1230 PM

4e Facility Neme (If not institution, give street and number)	4b. City, Town, or Locafion of Death	4c. County of Death
CALVERT MEMORIAL HOSPITAL	PRINCE FREDERICK	CALVERT

Funeral Director

5. Social Sacurity Numbar	6. Sax	7. Aga (In yrs. last birthday)	If Under 1 Year Months	Days	If Under 24 Hrs. Hours	Min.	8. Data of Birth (Month, Day, Yaar)	9. Birthplaca (Stata or Foraign Country)
218-08-1312	1☐ M 2☒ F	13 Yrs.					NOV. 18, 1984	MARYLAND

Usual Residenca of Decedant

10a. Stata	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	CALVERT	CHESAPEAKE BEACH	1☐ Yas 2☐ No

10e. Street and Number	10f. Zip Coda	10g. Citizan of Whef Countfry?
3251 KAREN DRIVE	20732	U.S.A.

11. Marital Status	12. Was Decedant Evar in U.S. Armed Forcas?	13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puerto Rican, atc.)	14. Race - American Indian, Black, Whita, etc.
1☒ Nevar Married 2☐ Married 3☐ Widowed 4☐ Divorced	1☒ Yes 2☐ No If Yas, Giva Yaar or Datas:	1☐ Yas 2☒ No Specify:	Specify: White

15. Dacadant's Education (Specify only highast grada complatad)		16a. Dacadant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired)	16b. Kind of Businass/Industry
Elementary/Secondery (0-12)	College (1-4or 5+)		
9		Student	High School

17. Fathar's Nama (First, Middla, Last)	18. Mothar's Nama (First, Middle, Maiden Sumama)
MARK THORN	DEBORAH GRANT

19a. Informent's Name/Ralationship (Type, Print)	19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda)
MARK THORN / FATHER	3251 KAREN DRIVE CHESAPEAKE BEACH, MARYLAND 20732

20a. Mathod of Disposition	20b. Piece of Disposition (Nama of cematery, crematory or othar placa)	Data	20c. Location - City or Town, Steta
1☐ Burial 2☒ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Specify)	Lee Crematory	Nov. 19, 1998	Clinton, Maryland

21. Signature of Funeral Service Licensee	22. Name end Address of Facility
	LEE FUNERAL HOME CALVERT, P.A. 8125 SOUTHERN MD BLVD. OWINGS, MARYLAND 20736

Physician /Medical Examiner

23a. Part I. Enter tha diseesa, or complicetions that caused the daath. Do not antar fhe mode of dying, such as cardiac or raspiratory arrest, shock, or heart failura. List only ona causa on aach lina.

		Approximata Intarval Batwaan Onsat and Daath
Immediata Causa (Final disaasa or condition rasulting in daath)	e. Head and Neck Injuries	
	Dua to (or as a consequanca of):	
Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Disaasa or injury that initiated avants rasulting in daath) Lest	b.	
	Dua to (or as a consequanca of):	
	c.	
	Dua to (or as a consequanca of):	
	d.	

Part II. **Other significant conditions** contributing fo daath but not rasulting in tha undarlying causa givan in Part I.

23b. **Did tobacco use contribute to the cauae of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Wera autopsy findings available prior to complation of cause of deeth?
1☒ Yes 2☐ No	1☒ Yes 2☐ No

25. Was casa refarrad to medical examinar?	26. Placa of Death (Check only ona)	
1☒ Yas 2☐ No	Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Rasidanca 6☐ Other (Specify)

27. Mannar of Daath	28a. Data of Injury (Month, Day Yaar)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐ Natural 2☒ Accident 3☐ Suicida 4☐ Homicida 5☐ Panding Investigation 6☐ Could not be datarmined	11-17-98	640 AM	1☐ Yas 2☒ No	motor vehicle collision

28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Specify)	28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata)
street	Christiana Farran Rd Huntington, Calvert Co., Md

29a. Cartifiar (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, data and placa, and dua to the ceuse(s) and mannar as stated. 2☒ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, deeth occurred at the tima, data and placa, and dua to fhe causa(s) and mannar stated.

29b. Signeture and title of certifier	29c. Licansa number	29d. Dete signed (Month, Day, Year)
Dennis J. Chute	O.C.M.E	NOV. 18, 1998

30. Nama and eddress of parson who completed causa of daath (Item 23a) (Type, Print)
Dennis J. Chute, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Data filad (Month, Day, Year)	32. Registrar's Signatura
NOV 24 1998	Penny B. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37347

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: James Thompson (James Edward Thompson)
2. Date of Death Month: 11 Day: 11 Year: 98
3. Time of Death: 10:55A
4a. Facility Name *(If not institution, give street and number)*: University of Maryland Medical Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 214-28-3657
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 68 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 4/8/30
9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10e. State: MD
10b. County: Caroline
10c. City, Town or Location: Goldsboro
10d. Inside City Limits: 1☐ Yes 2☐ No
10e. Street end Number: 26660 Sandtown Road
10f. Zip Code: 21636
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indien, Black, White, etc. *Specify:* White

15. Decedent's Educetion *(Specify only highest grede completed)*: Elementery/Secondery (0-12): 8 — College (1-4or 5+):
16e. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Boat Builder
16b. Kind of Business/Industry: Self

17. Father's Neme *(First, Middle, Last)*: Dorsey Thompson
18. Mother's Name *(First, Middle, Maiden Sumeme)*: Edith Smith

19a. Informent's Neme/Relationship *(Type, Print)*: Patricia Callahan - Daughter
19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 613 Goldsboro Street, Easton, MD 21601

20a. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removel from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*: Chesapeake Cremation Ctr. Date: Nov. 5, 1998
20c. Location - City or Town, State: Stevensville, MD

21. Signature of Funeral Service Licensee: Amy L. Michniewicz
22. Name end Address of Fecility: Fellows, Helfenbein & Newnam Funeral Home, P.A. 106 Shamrock Road, Chester, MD 21619

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

		Approximete Interval Between Onset end Death
Immediate Cause (Final disease or condition resulting in death)	a. Aspiration	< 1 day
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest	b. Non resectable pancreatic Cancer	
	Due to (or es a consequence of):	
	c.	
	Due to (or es e consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cauee of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an eutopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause ot death? 1☐ Yes 2☒ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Deeth: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28e. Dete of Injury *(Month, Dey Year)*
28b. Time ot Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and piece, end due to the cause(s) end manner as steted. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) and manner stated.

29b. Signeture end title of certifier: MD
29c. License number: P12487
29d. Date signed *(Month, Day, Year)*: 11/11/98

30. Name end address of person who completed cause of death (Item 23a) (Type, Print): Craig Skinner MD University of Maryland Medical Center Baltimore, MD 21201

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: NOV 13 1998
32. Registrar's Signeture: Geneva G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene.
Important: If Item 27 is marked other than "naturel", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37348

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Elizabeth Anne Tillman

2. Date of Death: Month Nov. Dey 2 Yeer 1998

3. Time of Death: 7:45 AM

4a. Facility Name (If not institution, give street and number): 5B Queen Victoria Way

4b. City, Town, or Location of Death: Chester

4c. County of Death: Queen Anne's

Funeral Director

5. Social Security Number: 219-18-9263

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 75 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept. 24, 1923

9. Birthplece (State or Foreign Country): MO

Usuel Residence of Decedent

10e. State: MD

10b. County: Queen Anne's

10c. City, Town or Location: Chester

10d. Inside City Limits: 1☐ Yes 2☐ No

10e. Street end Number: 5B Queen Victoria Way

10f. Zip Code: 21619

10g. Citizen of Whet Country?: USA

11. Maritel Stetus: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Yeer or Detes: 1943-1944

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elemantary/Secondary (0-12): 12 | College (1-4or 5+):

16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Self

17. Fether's Name (First, Middle, Last): Charles Lloyd Brown

18. Mother's Neme (First, Middle, Maiden Surname): Nancy Anne Jones

19e. Informent's Neme/Relationship (Type, Print): Col. H.G. Tillman Jr. - Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5B Queen Victoria Way, Chester, MD 21619

20e. Mathod of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Name of cemetery, crematory or other piece): Chesapeake Cremation Ctr. Dete: Nov. 5, 1998

20c. Location - City or Town, Stete: Stevensville, MD

21. Signeture of Funeral Servica Licensee: Chad M. Helfenbein

22. Name end Address of Facility: Fellows, Helfenbein & Newnam Fun. Home, P.A. 106 Shamrock Road Chester, MD 21619

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heert feilure. List only one cause on eech tine.

Approximete Intervel Between Onset end Deeth

Immediate Cause (Final disease or condition resulting in death)
e. METASTATIC hemangiopericytoma — 6yrs.

Due to (or es e consequenca of):
b. Hemangiopericytoma LEFT Thigh — 9yrs

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury thet initieted events resulting in deeth) Lest

Due to (or es a consequenca of):
c.

Due to (or es a consequenca of):
d.

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Ware eutopsy findings eveilable prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was casa referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be daterminad

28e. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To tha best of my knowledge, deeth occurred at tha tima, dete end plece, and dua to tha ceusa(s) and mannar es stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, data end pleca, end dua to the ceuse(s) and menner steted.

29b. Signeture and title of certifier: Frank T. Ward MD

29c. Licanse number: D33446 (MD)

29d. Date signed (Month, Day, Year): Nov 3, 98

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print): FRANK T. WARD MD Home Care Clinic, Ukrane, Upper Marlboro MD 20307

State Registrar

31. Dete filed (Month, Day, Year): NOV 04 1998

32. Registrer's Signeture: Louise B. Spates

Baltimore, Maryland 21215-0020

permit. Peges 1 and 2 should be filed within 72 hours efter death with the Marylend Department of Health end Mental Hygiene.
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Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37349

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Anna Thelma Townsend
2. Dete of Death (Month, Day, Year): October 18, 1998
3. Time of Death: 3:00p.m.
4e. Facility Neme *(If not institution, give street end number)*: 20995 Chester Avenue (Residence)
4b. City, Town, or Location of Death: Rock Hall
4c. County of Deeth: Kent

Funeral Director

5. Social Security Number: 218-34-3126
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthdey)*: 82 Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Dey, Yeer)*: October 25, 1915
9. Birthplece *(Stete or Foreign Country)*: Maryland

Usuel Residence of Decedent

10a. State: Maryland
10b. County: Kent
10c. City, Town or Location: Rock Hall
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street end Number: 20995 Chester Avenue
10f. Zip Code: 21661
10g. Citizen of Whet Country?: USA

11. Merital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grede completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Nurse
16b. Kind of Business/Industry: Health Care

17. Fether's Name *(First, Middle, Last)*: Samuel Hayward Urie
18. Mother's Neme *(First, Middle, Maiden Sumeme)*: Sadie Elizabeth Toulson

19e. Informent's Name/Relationship *(Type, Print)*: Mrs. Elizabeth Ann Kenny
19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 1207 Flores Avenue, Lady Lake, Florida 32159

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removel from State 4☐ Donation 5☐ Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, cremetory or other place)*: Wesley Chapel Cemetery — Dete: 10/23/98
20c. Location - City or Town, Stete: Rock Hall, Maryland

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Neme end Address of Feciliity: Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, MD 21620

To Be Completed by Funeral Director

permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Meryland Department of Health end Mental Hygiene.
Important: If item 27 is marked other than "natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset end Death
Immediate Cause (Final disease or condition resulting in death)	e. Cardiac Arrisythmia	1 min
	Due to (or es e consequence of):	
Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in deeth) Lest	b. Atherosclerotic Cardiovascular Disease	5 yrs
	Due to (or es e consequence of):	
	c.	
	Due to (or es e consequence of):	
	d.	

Part II. **Other significant conditione** contributing to death but not resulting in the underlying cause given in Part I.: ATRIAL FIBRILLATION; Congestive Heart Failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 1☐ Yes 2☒ No

25. Was case referred to medical exeminer? 1☐ Yes 2☒ No

26. Piece of Deeth *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Date of Injury *(Month, Dey Yeer)*
28b. Time of Injury
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Phyeician:** To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the beslis of exemineticn end/or investigation, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier: ▶ Helen A Noble MD
29c. License number: D41587
29d. Date signed *(Month, Dey, Yeer)*: 11/23/98

30. Neme end eddress ot person who completed cause of deeth (Item 23e) (Type, Print): Helen A. Noble, 122 Speer Road, Suite 5, Chesterotnw, Maryland 21620

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 30 1998
32. Registrer's Signeture: [signature]

To the Hospital or Attending Physician: The lew requires thet the death certificate be executed within 24 hours efter deeth.
To the Funeral Director: After this certificate hes been signed by the attending physician end completely filled in by the funerel director, pege 2 should be detached for use es the buriel-trensit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37350

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Leander Shelton Vanlandingham, Jr.

2. Dete of Deeth: Month November Dey 10 Year

3. Time of Deeth: 11:20 AM

4a Fecility Neme *(If not institution, give street and number)*: Suburban Hospital

4b. City, Town, or Location of Deeth: Bethesda

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 425-34-1938

6. Sex: 1☒M 2☐F

7. Age *(In yrs. last birthday)*: 73 Yrs.

If Under 1 Yeer: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Dey, Yeer)*: July 15, 1925

9. Birthplece *(State or Foreign Country)*: Tennessee

Usuel Residence of Decedent

10a. Stete: MD

10b. County: Montgomery

10c. City, Town or Location: Potomac

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street end Number: 10726 Stanmore Drive

10f. Zip Code: 20854

10g. Citizen of Whet Country?: United States of America

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates: 1943-46 1951-53

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.): 1☐Yes 2☒No *Specify:*

14. Rece - American Indian, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12) / College (1-4or 5+): 5+

16e. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Patent Attorney

16b. Kind of Business/Industry: Legal

17. Fether's Neme *(First, Middle, Last)*: Leander Shelton Vanlandingham, Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Bertha Mae Shumaker

19a. Informent's Neme/Reletionship *(Type, Print)*: (Wife) Henrietta Staph Vanlandingham

19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 10726 Stanmore Dr. Potomac, MD 20854

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removel from State 4☐Donetion 5☐Other *(Specify)*

20b. Piece of Disposition *(Name of cemetery, cremetory or other place)*: Hopewell Cemetery

Dete: 11/14/98

20c. Location - City or Town, Stete: McCool, MS

21. Signature of Funerel Service Licensee: Karen W. Porter

22. Name and Address of Facility: Porter Funeral Home P.O. Box 813 Louisville, MS 39339

Physician Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Interval Between Onset end Deeth

Immediate Ceuse (Final disease or condition resulting in deeth)

e. DIFUSE BOWEL NECROSIS

Due to (or es e consequence of):

Sequentially list conditions, if eny, leeding to immediete ceuse. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Lest

b. COMPARTMENT SYNDROME

Due to (or es e consequence of):

c. ILEUS

Due to (or es e consequence of):

d.

Part II. **Other significent conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

CUSHING SYNDROME

DIABETES MELLITUS

LIVER INSUFICIENCY.

23b. Did tobacco use contribute to the cauee of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24e. Wes en eutopsy performed? 1☐Yes 2☒No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Wes cese referred to medical exeminer? 1☐Yes 2☒No

26. Piece of Deeth *(Check only one)*: Hospital: 1☒Inpatient 2☐ER/Outpetient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Manner of Death: 1☒Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28e. Dete of Injury *(Month, Dey Yeer)*

28b. Time of Injury M

28c. Injury et Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of exemineticn end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end manner stated.

29b. Signature end title of certifier: [signature]

29c. License number: D 25177

29d. Date signed *(Month, Dey, Yeer)*: 11/11/98

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): Dr. Marco Belledonne 121 Congressional Lane Rockville, MD 20852

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 16 1998

32. Registrer's Signeture: Jeanne G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

VAN LANDINGHAM, LEANDER 11-10-98 12 PM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37351

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mary Mack Wilson
2. Date of Death (Month, Day, Year): November 8, 1998
3. Time of Death: 9:35 AM
4a. Facility Name *(If not institution, give street and number)*: Hillhaven Nursing Center
4b. City, Town, or Location of Death: Adelphi
4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 578-28-7976
6. Sex: 1☐ M 2☒ F
7. Age *(in yrs. last birthday)*: 96 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: May 16, 1902
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince Georges
10c. City, Town or Location: Adelphi
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3210 Powder Mill Road
10f. Zip Code: 20783
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Analytical Assistant
16b. Kind of Business/Industry: U.S. Government

17. Father's Name *(First, Middle, Last)*: John Mack
18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Butler

19a. Informant's Name/Relationship *(Type, Print)*: Gregory Dyson, grandson
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 219 Sunnyside Avenue, Piedmont, California 94611

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetary, cramatory or other place)*: Mt. Olivet Cemetery | Date: 11/14/98
20c. Location - City or Town, State: Washington, D.C.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: McGuire Funeral Service, Inc. 7400 Georgia Ave. N.W. Washington, D.C.

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

24a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Cerebral Vascular accident

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: arteriosclerosis generalized
Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury: M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] Tung Pi Lee MD
29c. License number: D26707
29d. Date signed *(Month, Day, Year)*: 11-12-98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): TUNG Pi Lee MD 700 Buckingham Dr Silver Spring MD 20901

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

4

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 17 1998
32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37352

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): KATHRYN REUTEMANN WILCOX
2. Date of Deeth: Month November, Dey 17, Year 1998
3. Time of Death: 9:00 AM
4a. Facility Neme (If not institution, give street and number): Suburban Hospital
4b. City, Town, or Location of Deeth: Bethesda
4c. County of Deeth: Montgomery

Funeral Director

5. Social Security Number: 577-30-1328
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 73 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Yeer): Dec. 9, 1924
9. Birthplace (State or Foreign Country): Washington, DC

Usuel Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 4800 Aspen Hill Road
10f. Zip Code: 20853
10g. Citizen of Whet Country?: United States

11. Maritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4or 5+): 2
16e. Decedent's Usuai Occupetion (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Fether's Name (First, Middle, Last): William A. Reutemann
18. Mother's Neme (First, Middle, Malden Sumeme): Kathryn Fleming

19a. informant's Name/Relationship (Type, Print): Kathleen Wilcox/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 19313 Dunbridge Way, Montgomery Village, MD 20886

20e. Method of Disposition: 1☒ Buriel 2☐ Cremation 3☐ Removei from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Gate of Heaven Cemetery
Date: November 20, 1998
20c. Location - City or Town, State: Silver Spring, Maryland

21. Signature of Funeral Service Licensee ? ▶ [signature] MO1126
22. Name end Address of Facility: Robert A. Pumphrey Funeral Home/ Rockville, Inc., 300 West Montgomery Avenue, Rockville, Maryland 20850-2805

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset end Deeth

Immediate Ceuse (Final disease or condition resulting in death): a. METASTATIC CARCINOMA OF THE BREAST

Due to (or es a consequence of):

Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Lest:

b. Due to (or es e consequence of):

c. Due to (or es e consequence of):

d.

Pert II. **Other significent conditione** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobecco use contribute to the ceuee of deeth? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveilable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Piece of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physicien:** To the best of my knowledge, death occurred et the time, dete end piece, end due to the cause(s) and menner es steted. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end manner stated.

29b. Signature and title of certifier: ▶ [signature], MD
29c. License number: D26571
29d. Date signed (Month, Day, Year): 11/17/98

30. Neme end address of person who completed cause of death (Item 23e) (Type, Print): IRVING MIZUS, MD 4930 DEL RAY AVE BETHESDA, MD 20814

State Registrar

31. Date filed (Month, Day, Year): NOV 20 1998
32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Drew

Kathryn Wilcox November 17, 1998 9:00 AM

6 (10)

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend #4a,11/25/98,BMW,Montg.Co.

Certificate of Death

Reg. No. 98 37353

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Walter F. White	November 17, 1998	10:50 AM

4a. Facility Name (If not institution, give street end number)	4b. City, Town, or Location of Death	4c. County of Death
50 West ~~Edmonstone~~ Edmonston Drive, #303	Rockville	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
109-10-3299	1☒ M 2☐ F	83 Yrs.			August 22, 1915	New Jersey

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Silver Spring	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
13819 North Gate Lane	20906	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☒ Yes 2☐ No If Yes, Give Yeer or Dates: World War II & Korea	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	-	Administrator	International Finance

17. Father's Name (First, Middle, Last)	18. Mother's Neme (First, Middle, Maiden Surname)
Felix White	Sophia Not Available

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Betty C. White/ Wife	13819 North Gate Lane, Silver Spring, MD 20906

20a. Method of Disposition	20b. Placa of Disposition (Name of cametery, crematory or other placa)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Parklawn Memorial Park	November 21, 1998	Rockville, Maryland

21. Signature of Funeral Service Licensee ▶ M00689

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Metastatic Pancreatic Cancer	2 Months
	Due to (or as a consequenca of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as e consequenca of):	
	d.	

Part II. **Other signifIcant conditIons** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Was an eutopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Doctor's office

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner es steted. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end placa, and due to the cause(s) end menner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	D33224	NOVEMBER 18, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Ram S. Trehan, M.D. 50 West Edmonston Drive, #303, Rockville, Maryland 20851

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 20 1998	Jenna G. Sparks

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37354

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last)	2. Dete of Deeth Month Dey Year	3. Time of Deeth
Jannie Waiters	November 17, 1998	3:50 AM

4a Fecility Neme (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Deeth
Suburban Hospital	Bethesda	Montgomery

Funeral Director

5. Sociel Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Yaar Months / Deys	If Under 24 Hrs. Hours / Min.	8. Dete of Birth (Month, Dey, Yeer)	9. Birthpleca (State or Foreign Country)
062-22-6327	1☐ M 2☒ F	83 Yrs.			March 26, 1915	South Carolina

Usual Residence of Decedent

10a. Stete	10b. County	10c. City, Town or Location	10d. Inside City Limits
New York	-	New York	1☒ Yes 2☐ No

10e. Street end Number	10f. Zip Code	10g. Citizen of Whet Country?
68 West 107th Street	10025	United States

11. Maritel Status	12. Wes Decedent Ever in U.S. Armed Forcas?	13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indien, Bleck, White, etc.
1☐ Naver Married 2☐ Marriad 3☒ Widowed 4☐ Divorced	1☐ Yas 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No *Specify:*	*Specify:* Black

15. Decedent's Education (Specify only highest grade completed)		16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	-	Factory Worker	Factory

17. Fether's Neme (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Sumema)
Charlton Dukes	Georgia Connally

19a. Informent's Neme/Relationship (Type, Print)	19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code)
Joann Waiters/ Daughter	5325 Massachusetts Ave., Bethesda, Maryland 20816

20e. Method of Disposition	20b. Place of Disposition (Neme of cemetery, cremetory or othar piece)	Dete	20c. Location - City or Town, Stete
1☒ Burial 2☐ Cremation 3☐ Remaval from Stata 4☐ Donetion 5☐ Other (Specify)	November 23, 1998 Mary Magdalene Cemetery		Lamar, South Carolina

21. Signature of Funeral Service Licensee ▶ [signature] M00689

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. metastatic colon cancer	1 month
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequance of):	
	c.	
	Due to (or as a consequanca of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☑ No	1☐ Yes 2☐ No

25. Wes case referred to medical examiner?	26. Plece of Deeth (Check only one)	
1☐ Yes 2☑ No	Hospital: 1☑ Inpatient 2☐ ER/Outpetient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Othar (Specify)

27. Menner of Death	28a. Dete of Injury (Month, Dey Year)	28b. Time of Injury M	28c. Injury at Work?	28d. Describe how injury occurred
1☑ Netural 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined			1☐ Yes 2☐ No	
	28e. Place of Injury - At home, ferm, straat, fectory, office building, etc. (Specify)			28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred et the time, dete end plece, and due to the cause(s) end manner es steted.
2☐ **Medical Examiner:** On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and placa, and dua to the cause(s) end menner stated.

29b. Signature and title of certifiar	29c. Licansa number	29d. Date signed (Month, Day, Year)
▶ George A Sotos MD	D43083	NOVEMBER 17, 1998

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print) GEORGE A. SOTOS, MD
9707 Medical Center Drive #300 Rockville MD 20850

State Registrar

31. Dete filed (Month, Day, Year)	32. Registrer's Signeture
NOV 20 1998	▶ Geneva G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Waiters, Jannie 11-17-98 0350

4

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37355

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month Day Year)	3. Time of Death
Robert P. Wade Jr.	November 10 1998	5:30am

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
9429 Mellonbrook Road	Columbia	Howard

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
040-52-2187	1☒M 2☐F	43 Yrs.			Feb 5, 1955	Connecticut

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Howard	Columbia	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
9429 Mellonbrook Road	21045	United States

11. Marital Status	12. Was Decedent Ever In U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	5+	Professor	Education

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Robert P. Wade Sr.	Irene Fitso

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Kim Poffenberger/Wife	9429 Mellonbrook Rd Columbia, Maryland 21045

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Metro Crematory	11-11-98	Catonsville, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Sean a Collins-Witzke	Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ANAPLASTIC ASTROCYTOMA	17 months
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Stuart Grossman MD	D73683	November 11, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
STUART A. GROSSMAN MD JOHNS HOPKINS ONCOLOGY CENTER BALTIMORE, MD

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 12 1998	▶ Geneva G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

15

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37356

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Meryl M. Walters

2. Date of Death Month Day Year: Nov 23, 1998

3. Time of Death: 2:55 PM

4a Facility Name *(If not institution, giva street and number)*: Fort Washington Hospital

4b. City, Town, or Location of Death: Fort Washington

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 425 14 8048

6. Sax: 1☐ M 2☒ F

7. Aga *(In yrs. last birthday)*: 82 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Yeer)*: March 27,1916

9. Birthplace *(Stata or Foreign Country)*: Mississippi

Usual Residence of Decedent

10a. State: MD

10b. County: P.G.

10c. City, Town or Location: Accokeek

10d. Inside City Limits: 1☐ Yes 2☐ No X

10e. Street and Number: 16009 Bealle Hill Road

10f. Zip Code: 20607

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, atc.) 1☐ Yes 2☒ No *Specify:*

14. Race - Americen Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: At Home

17. Father's Name *(First, Middla, Last)*: Julius Sullivan

18. Mothar's Name *(First, Middle, Maidan Sumama)*: Etta Wallace

19a. Informant's Name/Relationship *(Type, Print)*: Brenda &Jonathan Wright

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 16009 Bealle Hill Road, Accokeek, Md 20607

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Ramoval from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Nama of cemetery, crematory or other place)*: Memorial Gardens Cemetery

Date:

20c. Location - City or Town, State: Jones, Mississippi

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Facility: Lee Funeral Home,Inc 6633 Old Alexandria Ferry Road, Clinton,Md 20735

Physician /Medical Examiner

23a. Part1. Entar the disease, or complications that ceused the death. Do not anter tha moda of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Lung cancer — Approximate Interval: 2 months

Due to (or as a consequenca of):

Sequentially list conditions, if eny, leading to immadiata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Dua to (or as a consequance of):

d.

Part ii. **Other elgnificant conditions** contributing to death but not resulting in the underlying cause given in Part i.

23b. Did tobacco uee contribute to the cauae of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of ceusa of death? 1☐ Yes 2☐ No

25. Was cese referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ William T. Tanner

29c. License number: D35206

29d. Date signed *(Month, Day, Year)*: Nov. 24, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William T. Tanner, M.D. 11701 Livingston Road #101, Fort Washington, Md 20744

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 25 1998

32. Registrar's Signature: ▶ Penny G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel Hygiene. **Important: If item 27 is marked other than "natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

3

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37357

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Anna Yuditsky
2. Date of Death (Month, Day, Year): November 12, 1998
3. Time of Death: 3:15 P.M.

4a. Facility Name (If not institution, give street and number): Brooke Grove Nursing Home
4b. City, Town, or Location of Death: Olney
4c. County of Death: Montgomery County

Funeral Director

5. Social Security Number: 170-30-5583
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): January 2,1909
9. Birthplace (State or Foreign Country): Shenandoah Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 14411 Myer Terrace
10f. Zip Code: 20853
10g. Citizen of What Country? United States of America

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Simon Kupchinsky
18. Mother's Name (First, Middle, Maiden Surname): Anna Matulavich

19a. Informant's Name/Relationship (Type, Print): Dolores Yaroma/ Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14411 Myer Terrace, Rockville, Maryland 20853

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Our Lady of Fatima Cemetery | Date: November 16,1998
20c. Location - City or Town, State: Shenandoah, Pennsylvania

21. Signature of Funeral Service Licensee: ▶ Howard A Carson
22. Name and Address of Facility: Walukiewicz-Oravitz-Fell Funeral Home 132 South Jardin Street, Shenandoah, PA

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Pneumonia
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: b. Cerebrovascular Accident
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Date of Injury (Month, Day, Year)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ G. Thaker MD
29c. License number: D43430
29d. Date signed (Month, Day, Year): November 13, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Gaurang Thaker, M.D., 18111 Prince Philip Drive, Suite 212, Olney, Maryland

State Registrar

31. Date filed (Month, Day, Year): NOV 16 1998
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

98-6604-031
B.K.S
UNKNOWN 98-256 HATTEN YODER III

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37350

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Hatten S. Yoder, III
2. Date of Death (Month, Day, Year): NOV. 14, 1998
3. Time of Death: 0109 AM
4a. Facility Name *(If not institution, give street and number)*: ROUTE#29 & 195
4b. City, Town, or Location of Death: BURTONSVILLE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 215-62-4740
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 38 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: May 7, 1960
9. Birthplace *(State or Foreign Country)*: Washington, DC

Usual Residence of Decedent

10e. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Bethesda
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10a. Street and Number: 6709 Melody Lane
10f. Zip Code: 20817-3152
10g. Citizen of What Country?: United States

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 7; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Unemployable
16b. Kind of Business/Industry: N/A

17. Father's Name *(First, Middle, Last)*: Hatten S. Yoder, Jr.
18. Mother's Name *(First, Middle, Maiden Surname)*: Elizabeth M. Bruffey

19a. Informant's Name/Relationship *(Type, Print)*: Hatten S. Yoder, Jr./Father
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6709 Melody Lane, Bethesda, Maryland 20817-3152

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gate of Heaven Cemetery — Date: Nov. 19, 1998
20c. Location - City or Town, State: Silver Spring, MD

21. Signature of Funeral Service Licensee: David E. Perry · M00803
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Multiple Injuries
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? [X] Yes 2 [ ] No
26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other *(Specify)* AT SCENE
27. Manner of Death: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day, Year)*: 11-14-98
28b. Time of Injury: 0100 M
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: Pedestrian Struck by Auto
28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: Roadway
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: Rt 29

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: O.C.M.E
29d. Date signed *(Month, Day, Year)*: NOV. 14, 1998
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David R Fowler 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 16 1998
32. Registrar's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37359

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MAE ALINE ZIEGLER

2. Date of Death Month: NOVEMBER Day: 12 Year: 1998

3. Time of Death: 0907

4a. Facility Name (If not institution, give street and number): HOLY CROSS HOSPITAL

4b. City, Town, or Location of Death: SILVER SPRING

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 428-30-0143

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 5, 1924

9. Birthplace (State or Foreign Country): Mississippi

Usual Residence of Decedent

10a. State: Maryland | 10b. County: Montgomery | 10c. City, Town or Location: Silver Spring | 10d. Inside City Limits: 1☐ Yes 2☒ No

10a. Street and Number: 11501 Lamberton Court | 10f. Zip Code: 20902 | 10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): William J. Pearcy

18. Mother's Name (First, Middle, Maiden Surname): Rena Mae Robinson

19a. Informant's Name/Relationship (Type, Print): Arnold G. Ziegler (husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11501 Lamberton Court Silver Spring, Maryland 20902

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Arlington National Cemetery | Date: 11/19/98

20c. Location - City or Town, State: Arlington, Virginia

21. Signature of Funeral Service Licensee: Andrew J. Cole

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901

dmd

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

PARKINSONS DISEASE

ALZHEIMER'S DISEASE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M.D. (OME)

29c. License number: D15236

29d. Date signed (Month, Day, Year): NOVEMBER 13, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CARL I. MARGOLIS, M.D. 11125 ROCKVILLE PIKE, ROCKVILLE, MD 20852

State Registrar

31. Date filed (Month, Day, Year): NOV 16 1998

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37360

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: George Joseph Andrews

2. Dete of Death Month Day Year: December 1, 1998

3. Time of Death: 7:32 A.M.

4a Facility Name *(If not institution, give street and number)*: 771 Jennie Drive

4b. City, Town, or Location of Death: Severn

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 218-36-4863

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 63 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Nov. 14, 1935

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. Stete: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Severn

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 771 Jennie Drive

10f. Zip Code: 21144

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 58-'60

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+)

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Police Captain

16b. Kind of Business/Industry: Law Enforcement

17. Father's Name *(First, Middle, Last)*: John Victor Andrews

18. Mother's Name *(First, Middle, Maiden Surname)*: Agnes Korycky

19a. Informant's Name/Relationship *(Type, Print)*: Janice E. Andrews / Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 771 Jennie Drive Severn, MD 21144

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Crownsville MD Vet. Cem.

Date: Dec. 4, 1998

20c. Location - City or Town, State: Crownsville, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Kirkley-Ruddick Funeral Home 421 Crain Hwy. S.E. Glen Burnie, MD 21061

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset and Death

Immediete Ceuse (Final disease or condition resulting in death)

e. Metastatic Transitional Cell Carcinoma of the Kidney — 7 mos.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Transitional Cell Carcinoma of the Kidney — 2 yrs.

Due to (or as a consequence of):

c.

Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Was cese referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physicfen:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D31551

29d. Date signed *(Month, Day, Year)*: December 3, 1998

30. Name and address of persen who completed cause of death (Item 23a) (Type, Print): Russell DeLuca, M.D. 1600 Crain Hwy. S. Glen Burnie, MD 21061

State Registrar

31. Dete filed *(Month, Day, Year)*: DEC 07 1998

32. Registrar's Signature: [signature] G. Sparks

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37361

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: CHARLES ASKEW

2. Data of Death — Month: 12 Day: 3 Year: 98

3. Time of Death: 8:50 AM

4a. Facility Name *(If not institution, give street and number)*: Oak Crest Care Facility

4b. City, Town, or Location of Death: Parkville

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 215-10-8316

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 87 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 04/05/1911

9. Birthplace *(State or Foreign Country)*: PENNSYLVANIA

Usual Residence of Decedent

10a. State: Md.

10b. County: Baltimore

10c. City, Town or Location: Parkville

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 8820 Walther Blvd.

10f. Zip Code: 21234

10g. Citizen of What Country?: U.S.A.

11. Maritel Stetus: 1 ☐ Naver Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1 ☐ Yas 2 ☐ No — If Yas, Giva Yaar or Datas:

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.): 1 ☐ Yas 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, atc. *Specify:* WHITE

15. Decedent's Education *(Spacify only highast grada completed)*: Elementary/Secondary (0-12): — College (1-4or 5+): 2

16a. Decedent's Usual Occupation *(Giva kind of work done during most of working lifa. DO NOT use retired)*: Real Estate Agent

16b. Kind of Businass/Industry: Real Estate

17. Father's Nama *(First, Middle, Last)*: Charles Askew

18. Mothar's Nama *(First, Middle, Maidan Surnama)*: Nellie Reeve

19a. Informant's Name/Ralationship *(Type, Print)*: Michael C. Virden/Great Nephew

19b. Mailing Address *(Straat and Number or Rurel Routa Numbar, City or Town, Stata, Zip Cada)*: 3917 Don Mill Ct. Ellicott City, Md. 21043

20a. Mathod of Disposition: 1 ☑ Burial 2 ☐ Cramation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Nama of cemafary, crematory or other place)*: Dulaney Valley Mem. Grds. — Data: 12/7/98

20c. Locatlon - City or Town, Stata: Timonium, Maryland

21. Signature of Funeral Service Licensee: Michael J. Rudy

22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204

Physician /Medical Examiner

23a. Part1. Enter tha diseasa, or complications that caused tha death. Do not antar the moda of dying, such as cardiac or raspiratory arrast, shock, or haart failure. List only one causa on aach line.

Approximata Intarval Between Onsat and Death

Immediata Causa (Finel disaasa or condition rasulting in death): a. Dementia — years

Due to (or as a consequance of):

Sequantially list conditions, if any, leading to immadiata causa. Entar Underlying Causa (Disaasa or injury that initiated avents rasulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequance of):

d.

Part II. **Othar significant conditions** contributing to death but not rasulting in tha underlying cause givan in Part I.

23b. Did tobacco usa contributa to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yas 2 ☑ No

24b. Wara autopsy findings available prior to completion of causa of deeth? 1 ☐ Yas 2 ☑ No

25. Was casa referred to medical examinar? 1 ☐ Yas 2 ☑ No

26. Place of Deeth *(Check only one)*: Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA — Othar: 4 ☑ Nursing Home 5 ☐ Rasidance 6 ☐ Othar *(Specify)*

27. Mannar of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicida 4 ☐ Homicida 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Data of Injury *(Month, Day Yaar)*

28b. Tima of Injury

28c. Injury at Work? 1 ☐ Yas 2 ☐ No

28d. Dascribe how injury occurred

28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. *(Spacify)*

28f. Location *(Straat and Number or Rural Routa Numbar, City or Town, Stata)*

29a. Certifiar *(Check only one)*: 1 ☑ **Certifying Physician:** To tha bast of my knowladge, deeth occurred at the time, date and placa, and dua to the causa(s) and mannar as stated. 2 ☐ **Medical Examinar:** On the basis of axamination and/or invastigation, in my opinion, daath occurrad at tha time, dete end placa, end dua to the cause(s) and mannar statad.

29b. Signatura and title of certifiar: Kevin Bishoff Carlson, MD

29c. License number: D 0053636

29d. Date signad *(Month, Day, Year)*: December 3, 1998

30. Name and eddress of person who completad cause of daath (Item 23a) (Type, Print): KEVIN BISHOFF CARLSON 3460 Ellicott Center Drive, Ellicott City, MD 21043

State Registrar

31. Data filed *(Month, Day, Yaar)*: DEC 07 1998

32. Registrar's Signatura: Geneva B. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death Certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37362

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: IANTHA BENTON
2. Date of Death Month / Day / Year: November 30, 1998
3. Time of Death: 8:55pm
4e. Facility Name *(If not institution, give street and number)*: North Arundel Hospital
4b. City, Town, or Location of Death: Glen Burnie
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 214-30-3910
6. Sex: 1☐ M 2☑ F
7. Age *(In yrs. last birthday)*: 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: SEPT. 12, 1908
9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10e. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: TOWSON
10d. Inside City Limits: 1☐ Yes 2☑ No
10e. Street and Number: 8415 BELONA LANE
10f. Zip Code: 21204
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☑ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 10 | College (1-4or 5+):
16e. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: MANAGER
16b. Kind of Business/Industry: RETAIL SALES

17. Father's Name *(First, Middle, Last)*: WILLIAM H. CLOSE
18. Mother's Name *(First, Middle, Maiden Surname)*: IANTHA CLARK

19e. Informent's Name/Reletionship *(Type, Print)*: MARY SINGHASS, DAUGHTER
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 8415 BELONA LA. # 416 TOWSON, MD. 21204

20a. Method of Disposition: 1☑ Burial 2☐ Cremelion 3☐ Removal from State 4☐ Donelion 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: LAKEVIEW MEMORIAL PK
Date: DEC 3, 1998
20c. Location - City or Town, State: SYKESVILLE, MD.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: EVANS CHAPEL OF CHIMES 2325 YORK RD. TIMONIUM, MD. 21093

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one ceuse on eech line. *(Approximate Interval Between Onset and Death)*

Immediate Ceuse (Final disease or condition resulting in death)
e. SEPTICEMIA

Due to (or as e consequence of):

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest
b. ATRIAL FIBRILLATION

Due to (or es e consequence of):
c.

Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24e. Was en eutopsy performed? 1☐ Yes 2☑ No
24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Wes cese referred to medicel exeminer? 1☐ Yes 2☑ No
26. Plece of Deeth *(Check only one)*: Hospitel: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28e. Date of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end manner es stated. 2☐ **Medical Examiner:** On the basis of exeminetion end/or investigetion, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) end manner stated.

29b. Signature end title of certifier: [signature] MD
29c. License number: D43977
29d. Date signed *(Month, Dey, Year)*: November 30 1998

30. Neme end eddress of person who completed ceuse of death (Item 23e) (Type, Print): Eugene Dreiwitz · 301 Hospital Drive, Glen Burnie, MD. 21061

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 07 1998
32. Registrer's Signeture: [signature] D. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that this death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 37363

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Albert J Bachmann
2. Dete of Deeth: Month December Dey 01 Yeer 1998
3. Time of Death: 20:00
4a. Facility Name (If not institution, give street end number): Good Samaritan Hospital
4b. City, Town, or Location of Deeth: BALTIMORE CITY
4c. County of Deeth: —

Funeral Director

5. Social Security Number: 215-18-9141
6. Sex: 1☑M 2☐F
7. Age (In yrs. lest birthdey): 77 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Yeer): DEC. 3, 1920
9. Birthplace (Stete or Foreign Country): MD.

Usuel Residence of Decedent

10a. State: MD
10b. County: —
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☑Yes 2☐No
10e. Street end Number: 4006 HAMILTON AVENUE
10f. Zip Code: 21206
10g. Citizen of Whet Country?: U.S.A.
11. Maritel Status: 1☐Never Married 2☑Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☑Yes 2☐No If Yes, Give Yeer or Dates:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐Yes 2☑No Specify:
14. Race - American Indien, Bleck, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grede completed): Elementery/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): MANAGER
16b. Kind of Business/Industry: UNITED STATES GOVERNMENT DEPOT
17. Fether's Name (First, Middle, Last): JOHN W. BACHMANN
18. Mother's Name (First, Middle, Meiden Surname): CARRIE K. EYDELLOTH
19a. Informent's Name/Reletionship (Type, Print): KATHERINE BACHMANN, SPOUSE
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 4006 HAMILTON AVE. BALTIMORE, MD. 21206
20a. Method of Disposition: 1☑Burial 2☐Cremetion 3☐Removel from State 4☐Donetion 5☐Other (Specify)
20b. Plece of Disposition (Neme of cemetery, cremetory or other plece): PARKWOOD CEMETERY
Date: DEC. 3, 1998
20c. Location - City or Town, Stete: PARKVILLE, MD.
21. Signature of Funerel Service Licensee: Keith L. Wells
22. Neme end Address of Facility: EVANS CHAPEL OF MEMORIES 8500 HARFORD RD. PARKVILLE, MD. 21234

Physician /Medical Examiner

23a. Pert I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert failure. List only one cause on each line.

Approximete Interval Between Onset end Death

Immediete Ceuse (Final disease or condition resulting in deeth)
a. Atherosclerotic Coronary artery disease 4 years
Due to (or es e consequence of):
b. Chronic obstructive Lung Disease 10 years
Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting in deeth) Lest
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Pert II. **Other significent conditions** contributing to death but not resulting in the underlying ceuse given in Part I.
End stage Renal disease
Atherosclerotic Peripheral Vascular disease

23b. **Did tobacco use contribute to the cauee of death?** 1☑Yes 2☐No 3☐Probably 4☐Unknown

24a. Wes en eutopsy performed? 1☐Yes 2☑No
24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 1☐Yes 2☐No

25. Wes case referred to medical examiner? 1☐Yes 2☒No
26. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)
27. Manner of Deeth: 1☒Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigation 6☐Could not be determined
28a. Dete of Injury (Month, Dey Yeer)
28b. Time of Injury M
28c. Injury et Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es stated. 2☐**Medical Examiner:** On the besis of exeminetion end/or investigetion, in my opinion, death occurred et the time, date end place, end due to the cause(s) end menner stated.
29b. Signeture end title of certifier: S Frimpong - Resident
29c. License number: P 12559
29d. Date signed (Month, Dey, Yeer): December 1, 1998
30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): Samuel Frimpong, Good Samaritan Hsp. P.O. Box 401, BALT. MD 21239

State Registrar

31. Date filed (Month, Day, Year): DEC 07 1998
32. Registrar's Signeture: Sandra G. Sparks

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use by the burial-transit

15

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37364

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): PHYLLIS ANN BERGENBACK
2. Date of Death Month: December Day: 4 Year: 1998
3. Time of Death: 345 PM
4a. Facility Name (If not institution, give street and number): Carroll County Gerenal Hospital
4b. City, Town, or Location of Death: Westminster
4c. County of Death: Carroll County

Funeral Director

5. Social Security Number: 036-26-1450
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 59 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 15, 1939
9. Birthplace (State or Foreign Country): Rhode Island

Usual Residence of Decedent

10a. State: Maryland
10b. County: Carroll
10c. City, Town or Location: Westminster
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2732 Albert Rill Road
10f. Zip Code: 21157
10g. Citizen of Whet Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Merned 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Rece - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 Years | College (1-4or 5+):
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Assistant Office Mananger
16b. Kind of Business/Industry: Norris Ford

17. Father's Name (First, Middle, Last): Not Known Bailey
18. Mother's Name (First, Middle, Maiden Surname): Dorothy Carr

19a. Informent's Name/Reletionship (Type, Print): Husband Mr. Ronald L. Bergenback
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2732 Albert Rill Road Westminster, MD 21157

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from Stete 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, crematory or other piece): Meadowridge Mem. Pk. Date: 12/7/1998
20c. Location - City or Town, Stete: Dorsey, Maryland

21. Signature of Funeral Service Licensee: Chad W. Fisher
22. Neme end Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death): a. METASTATIC PANCREATIC CARCINOMA — 1 MONTH

Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or es a consequence of):
c.
Due to (or es e consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings eveilebia prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospitel: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner as stated. 2☐ **Medicat Examiner:** On the besis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: Dan H. Schreibfeder MD
29c. License number: D28221
29d. Date signed (Month, Day, Year): December 4, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAN H. SCHREIBFEDER, MD CARROLL COUNTY GENERAL HOSPITAL

State Registrar

31. Date filed (Month, Day, Year): DEC 07 1998
32. Registrar's Signature: Denise B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 37365

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Nama (First, Middla, Last): JAMES HENRY BLACKWELL SR.
2. Data of Death Month: December Day: 2 Yaar: 1998
3. Tima of Death: 8:15 PM
4a. Facility Nama (If not institution, give street and number): UNION MEMORIAL HOSPITAL
4b. City, Town, or Locatlon of Daath: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 252-20-0149
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 82 Yrs.
If Under 1 Year: Months / Deys
If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): JULY 23, 1916
9. Birthplaca (Stata or Foraign Country): GEORGIA

Usual Rasidanca of Decedant

10a. State: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE CITY
10d. Insida City Limits: 1 [X] Yas 2 [ ] No
10e. Street and Number: 41 EAST 25TH STREET
10f. Zip Code: 21218
10g. Citizen of Whet Country?: USA

11. Maritel Status: 1 [ ] Navar Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedant Evar in U.S. Armed Forces? 1 [ ] Yas 2 [X] No If Yas, Giva Yaar or Datas:
13. Was Decedant of Hispenic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxicen, Puarto Rican, atc.) 1 [ ] Yas 2 [X] No Specify:
14. Race - Amaricen Indian, Black, White, atc. Specify: BLACK

15. Dacedant's Educetion (Spacify only highast grada complatad): Elementary/Secondary (0-12): 7TH GRADE; College (1-4or 5+):
16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT usa ratired): JANITORIAL
16b. Kind of Businass/Industry: JOHNS HOPKINS UNIVERSITY

17. Fathar's Nama (First, Middla, Last): ANDREW BLACKWELL
18. Mothar's Name (First, Middla, Maiden Surname): BETTY BLACKWELL

19a. Informant's Nama/Relationship (Type, Print): JOE BLACKWELL (SON)
19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code): 2522 McCULLOH STREET, BALTIMORE, MD. 21217

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Ramoval from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Nama of camatery, crematory or othar place): BALTIMORE CEMETERY
Data: 12-7-98
20c. Locetion - City or Town, State: BALTIMORE, MARYLAND

21. Signature of Fumaral Sarvice Licensaa: ▶ [signature] D. Br
22. Nama and Addrass of Facility: JOSEPH H. BROWN JR. FUNERAL HOME, PA 2140 N. FULTON AVE., BALTIMORE, MD. 21217

Physician /Medical Examiner

23a. Part1. Entar tha disaase, or complications thet caused the deeth. Do not antar tha moda of dying, such es cardiac or respiretory arrest, shock, or heart failura. List only ona causa on aach lina.

Approximata Intarval Batween Onsat and Daath

Immediata Causa (Finel diseasa or condition resulting in death):
e. PULMONARY EDEMA + CONGESTION — 6 hrs.

Due to (or as e consequance of):
b. SEVERE METABOLIC ACIDOSIS — 6 hrs.

Sequantially list conditions, if any, laading to immadiate ceusa. Entar Underlying Ceuse (Disaasa or injury that initiatad avants resulting in death) Last

Due to (or as a consaquance of):
c.

Due to (or as a consaquance of):
d.

Part II. **Other significant conditions** contributing to daath but not rasulting in tha underlying ceusa givan in Part I.

Hemorrhagic esophagitis + gastritis
RENAL INSUFFICIENCY

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performad? 1 [X] Yes 2 [ ] No

24b. Wara autopsy findings available prior to completion of ceuse of death? 1 [ ] Yas 2 [ ] No

25. Was cesa referred to madical examinar? 1 [ ] Yas 2 [X] No

26. Placa of Death (Chack only ona): Hospital: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Othar: 4 [ ] Nursing Homa 5 [ ] Residence 6 [ ] Othar (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accidant 3 [ ] Sulcida 4 [ ] Homicida 5 [ ] Pending investigation 6 [ ] Could not be determinad

28a. Data of Injury (Month, Day Year)
28b. Tima of Injury
28c. Injury at Work? 1 [ ] Yas 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At homa, farm, straat, factory, offica building, atc. (Specify)
28f. Location (Straat and Number or Rural Route Number, City or Town, Stata)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician**: To the best of my knowledge, death occurred at tha tima, data and place, and dua to tha cause(s) and mannar as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, daath occurred at the time, date and place, and dua to the causa(s) and manner stated.

29b. Signatura and titla of certifier: ▶ Carlos M. Orbegoso M.D.
29c. Licansa number: D15354
29d. Date signed (Month, Day, Year): December 3, 1998

30. Nama end addrass of person who completed causa of daath (Item 23a) (Type, Print): CARLOS M. ORBEGOSO M.D. UMH, 201 E. UNIV. PKWY. BALTO. MD 21218

State Registrar

31. Data filed (Month, Day, Year): DEC 07 1998
32. Registrar's Signatura: [signature] G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

James H. Blackwell
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6 BSS

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Item#10g perFH G766 12/07/98 EW

Reg. No. 98 37366

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: JAMES BENBOW

2. Dete of Death Month / Day / Yaar: DECEMBER 2 98

3. Time of Death: 4:19 P.M.

4e Fecility Name *(If not institution, give street end number)*: NORTHWEST HOSPITAL CENTER

4b. City, Town, or Location of Death: RANDALLSTOWN

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 251-84-2743

6. Sex 1☒M 2☐F

7. Age *(In yrs. last birthday)*: 50 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.

8. Deta of Birth *(Month, Dey, Yeer)*: 04 02 48

9. Birthptece *(State or Foreign Country)*: S.C.

Usuel Residence of Decedent

10a. Stata: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits 1☒Yes 2☐No

10e. Street end Number: 6735 Foxmeadow Road

10f. Zip Code: 21207

10g. Citizen of Whet Country?: U.S.A~~A~~

11. Marital Status 1☒Nevar Marriad 2☐Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispenic Origin? (Spacify Yas or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 1☐Yes 2☐~~☒~~No *Specify:*

14. Race - American Indien, Black, Whita, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grede completed)*: Elementary/Secondary (0-12): 10th grade | College (1-4or 5+): na

16e. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Cook

16b. Kind of Business/Industry: Backfin Restaurant

17. Fathar's Neme *(First, Middle, Last)*: Joseph Benbow

18. Mother's Name *(First, Middla, Maiden Surneme)*: Clotell Felder

19a. Informent's Name/Relationship *(Type, Print)*: Mae Benbow-Niece

19b. Meiling Address *(Street end Number or Rurel Route Number, City or Town, State, Zip Code)*: 6735 Foxmeadow Road, Baltimore Md 21207

20e. Method of Disposition ☒Buriat 2☐Cramation 3☐Ramovel from State 4☐Donetion 5☐Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other place)*: Arbutus Memorial Park | Data: 12/9/98

20c. Location - City or Town, Stete: Arbutus, Md

21. Signatura of Funaral Sarvice Licensaa: Gabrielle Cook

22. Name and Address of Facility: March F/H West 4300 Wabash Ave, Baltimore Md 21215

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused tha death. Do not enter the mode of dying, such es cerdiec or respiratory errest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onsat and Death

Immediete Ceuse (Finel diseese or condition resulting in death)

a. CARDIAC ARREST — 4 DAYS

Due to (or es e consequence of):

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest

b. ACUTE MYOCARDIAL INFARCTION — 4 DAYS

Due to (or es a consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying cause given in Part I.

DIABETES

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Wes en eutopsy performed? 1☐Yes 2☒No

24b. Were eutopsy findings eveileble prior to completion of ceuse of death? 1☐Yes 2☐No

25. Wes cese referred to medical examiner? 1☐Yes 2☒No

26. Piece of Death *(Check only one)*: Hospital: 1☒Inpatient 2☐ER/Outpetient 3☐DOA Other: 4☐Nursing Home 5☐Rasidence 6☐Other *(Specify)*

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigation 6☐Could not be determined

28e. Dete of Injury *(Month, Dey Year)* | 28b. Time of Injury M | 28c. Injury et Work? 1☐Yes 2☐No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)* | 28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)* 1☒**Certifying Physician**: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end manner es steted. 2☐**Medical Examiner**: On the besis of examination end/or invastigation, in my opinion, death occurred et the time, dete end plece, end due to tha ceuse(s) and mannar stated.

29b. Signature and titla of certifier: K.S.RAO.M.D

29c. Licensa number: D43462

29d. Data signed *(Month, Dey, Year)*: DECEMBER 2 1998

30. Neme end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print): K.S.RAO.M.D. NORTHWEST HOSPITAL CENTER, RANDALLSTOWN MD

State Registrar

31. Dete filed *(Month, Day, Year)*: DEC 07 1998

32. Registrer's Signeture

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 37367

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: FRAULINE BROWN

2. Dete of Death Month / Dey / Year: December 2 1998

3. Time of Deeth: 12:10 P.M.

4a Fecility Name *(If not institution, give street and number)*: FRANKlin SQUARE HospiTAl CenTER

4b. City, Town, or Location of Deeth: Rosedale

4c. County of Deeth: BALTimore

Funeral Director

5. Social Security Number: 234-26-0361

6. Sex: 1☐M 2☒F

7. Age *(In yrs. last birthdey)*: 78 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Dey, Yeer)*: Oct.10 1920

9. Birthplece *(Stete or Foreign Country)*: West Virginia

Usual Residence of Decedent

10a. State: Md.

10b. County: Baltimore

10c. City, Town or Location: Essex

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 401 Margaret Ave.

10f. Zip Code: 21221

10g. Citizen of What Country?: USA

11. Merital Stetus: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*

14. Race - American Indien, Black, White, etc. *Specify:* White

15. Decedent's Eduction *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12th; College (1-4or 5+):

16e. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Riveter

16b. Kind of Business/Industry: Martin's

17. Fether's Neme *(First, Middle, Last)*: Irvin Miller

18. Mother's Name *(First, Middle, Maiden Sumame)*: Ida Williams

19a. Informent's Name/Reletionship *(Type, Print)*: Earl Brown / husband

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 401 MArgaret Ave. Baltimore Md. 21221

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Holly Hill Cemetery

Dete: 12/4/98

20c. Location - City or Town, State: Balitmore Md.

21. Signature of Funeral Service Licensee: ▶ R. Terry Connelly

22. Name end Address of Fecility: Connelly Funeral Home of Essex 300 MAce AVe. Balitmore Md. 21221

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert feilure. List only one cause on eech line.

Approximate Intervel Between Onset end Death

Immediate Cause (Final disease or condition resulting in death) e. End STage PARKinson's Disease — 12 yeARS

Due to (or es e consequence of):

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest

b. Due to (or es e consequence of):

c. Due to (or es e consequence of):

d.

Pert II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

UROsepsis, HyperTension, CORONARY ARTERY Disease CEREBROVASCULAR AccidenT

23b. Did tobacco use contribute to the causs of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Wes en eutopsy performed? 1☐Yes 2☒No

24b. Were eutopsy findings available prior to completion of ceuse of deeth? 1☐Yes 2☐No

25. Was case referred to medicel examiner? 1☐Yes 2☒No

26. Place of Death *(Check only one)*: Hospital: 1☒Inpatient 2☐ER/Outpetient 3☐DOA; Other: 4☐Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Manner of Deeth: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day Yeer)*

28b. Time of Injury M

28c. Injury et Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒**Certifying Physician**: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner es steted. 2☐**Medicat Examiner**: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner stated.

29b. Signeture end title of certifier: ▶ Marco Somora MD

29c. License number: D40819

29d. Date signed *(Month, Dey, Yeer)*: December 2, 1998

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): DR. MARCO SOMPRA 9000 FRANKlin SQUARE DR. BALTIMORE MARYland 21237

State Registrar

31. Date filed *(Month, Dey, Yeer)*: DEC 07 1998

32. Registrer's Signeture: D. Sparks

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

FRAULINE BROWN

5

90 37368

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): James Brown
2. DATE OF DEATH (Month, Day, Year): Dec 3 1998
3. TIME OF DEATH: 9:30 AM
4. SOCIAL SECURITY NUMBER: 215306057
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 64 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)
7. DATE OF BIRTH (Month, Day, Year): 2 16 34
8. BIRTHPLACE (State or Foreign Country): M.D.
9a. FACILITY NAME (If not institution, give street and number): Irvington Knoll Nursing Center
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore MD
9c. COUNTY OF DEATH: USA

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: NA
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 4438 Cedar Garden Road
10f. ZIP CODE: 21229
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4 or 5+): 2yrs
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Detail Man
16b. KIND OF BUSINESS/INDUSTRY: Car Wash
17. FATHER'S NAME (First, Middle, Last): Brown
18. MOTHER'S NAME (First, Middle, Maiden Surname): Martha Smith
19a. INFORMANT'S NAME (Type/Print): Brenda Young-Daughter
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4438 Cedar Garden Road, Baltimore Md 21229
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) _____
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Metro Crematory Inc — DATE: 12/5/98
20c. LOCATION — City or Town, State: Baltimore, Md
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Lola March
22. NAME AND ADDRESS OF FACILITY: March F/H West, 4300 Wabash Ave, Baltimore Md 21215

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	End Stage Renal disease	1yr.
DUE TO (OR AS A CONSEQUENCE OF): b.	Hypertension	years
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c.		
DUE TO (OR AS A CONSEQUENCE OF): d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [X]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Amatun M Haeem M.D
29c. LICENSE NUMBER: D 15503
29d. DATE SIGNED (Month, Day, Year): Dec 4 1998
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 501 Dolphin Street, Baltimore, MD 21217
31. DATE FILED (Month, Day, Year): DEC 07 1998
32. REGISTRAR'S SIGNATURE: Geneva D. Sparks

DHMH-16 Rev 1/89

98-6876-005
B.K.S

SUSAN BAKER

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 37369

Items: 23 part I,27 per MEO G-766 12/9/98 reb *Certificate of Death*

Reg. No.

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Susan Eileen Baker
2. Dete of Deeth — Month: NOV. Dey: 24, Year: 1998
3. Time of Deeth: 11:52 AM
4a Fecility Name *(If not institution, give street and number)*: FRANKLIN SQUARE HOSPITAL
4b. City, Town, or Location of Deeth: ESSEX
4c. County of Death: BALTIMORE

Funeral Director

5. Sociel Security Number: 218-60-9861
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 46 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Day, Year)*: Dec. 16 1951
9. Birthplece *(State or Foreign Country)*: Maryland

Usuel Residence of Decedent

10a. State: Md.
10b. County: Baltimore
10c. City, Town or Location: Essex
10d. Inside City Limits: 1☐ Yes 2☐ No XX
10e. Street and Number: 509 Myrth Ave.
10f. Zip Code: 21221
10g. Citizen of Whet Country?: USA
11. Meritel Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No If Yes, Give Year or Detes:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - Americen Indien, Bleck, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 2yrs
16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: supervisor-Special Services
16b. Kind of Business/Industry: EssexCommunityCollege
17. Fether's Neme *(First, Middle, Last)*: Reich Riessler
18. Mother's Name *(First, Middle, Maiden Surname)*: Margaret Patruska
19e. Informent's Neme/Relationship *(Type, Print)*: Warren K. Baker / husband
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 509 Myrth Ave. Baltimore Md. 21221
20e. Method of Disposition: 1☒ Buriel 2☐ Cremation 3☐ Removal from Stete 4☐ Donetion 5☐ Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, crematory or other place)*: Holly Hill Cemetery
Dete: 11/28/98
20c. Location - City or Town, Stete: Baltimore Md. 21221
21. Signature of Funerel Service Licensee: R. Terry Connelly
22. Name and Address of Fecility: Connelly Funeral HOme of Essex 300 Mace AVe. Baltimore Md. 21221

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on eech line.

Approximate Intervel Between Onset end Death

Immediate Cause (Finel diseese or condition resulting in death): e. Seizure Disorder

Due to (or es e consequence of):

Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in death) Lest:
b. Due to (or es e consequence of):
c. Due to (or as e consequence of):
d.

Pert II. **Other significent conditions** contributing to deeth but not resulting in the underlying cause given In Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Wes en eutopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings eveilable prior to completion of ceuse of deeth? 1☒ Yes 2☐ No

25. Wes cese referred to medical exeminer? XX 1☐ Yes 2☐ No

26. Place of Deeth *(Check only one)*: Hospitel: 1☐ Inpetient XX ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Deeth: X 1☒ Neturel 2☐ Accident 3☐ Sulcide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Dete of Injury *(Month, Day Yeer)*
28b. Time of Injury
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(s) end menner es steted. 2☒ **Medical Examiner:** On the besis of exemnetion end/or investigation, in my opinion, death occurred et the time, dete end place, and due to the ceuse(s) and manner stated.

29b. Signature end title of certifier
29c. License number: O.C.M.E
29d. Date signed *(Month, Day, Year)*: NOV. 26, 1998

30. Neme end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print): David R. Fowler 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed *(Month, Day, Year)*: DEC 07 1998
32. Registrer's Signature: Geneva G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 37370

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Jennie Naomi Belz
2. Date of Death Month Dey Yeer: Dec 6, 1998
3. Time of Death: 4:30pm
4e. Facility Neme (If not institution, give street end number): Manor Care Ruxton
4b. City, Town, or Location of Deeth: Towson
4c. County of Death: Baltimore Co.

Funeral Director

5. Social Security Number: 215-10-5910
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 91 Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Yeer): May 6, 1907
9. Birthpiece (Stete or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Towson
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street end Number: 7001 North Charles Street
10f. Zip Code: 21204
10g. Citizen of Whet Country?: U.S.A

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed): Elementary/Secondary (0-12): 8 — College (1-4or 5+):
16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): Home Maker
16b. Kind of Business/Industry: Own Home

17. Fether's Name (First, Middle, Last): Arthur F. Gosnell
18. Mother's Name (First, Middle, Maiden Sumeme): Alice Harding

19e. Informent's Neme/Reletionship (Type, Print): Peter Belz, Jr. (Son)
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 3739 Beech Avenue, Baltimore, Maryland 21211

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Name of cemetery, crematory or other piece): New Cathedral Cemetery
Dete: 12/10/98
20c. Location - City or Town, Stete: Baltimore, Maryland

21. Signeture of Funeral Service Licensee: A. Alan Seitz, Jr.
22. Neme end Address of Fecility: A. Alan Seitz, Jr. Funeral Home 3818 Roland Avenue, Baltimore, Maryland 21211

Physician /Medical Examiner

23a. Pert 1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert failure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Death

Immediate Ceuse (Final disease or condition resulting in death): e. ALZHEIMER'S DISEASE — Years.
Due to (or es e consequenca of):
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting in deeth) Last:
b.
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.: ARTHRITIS

23b. Did tobecco use contribute to the cause of deeth? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28e. Dete of Injury (Month, Dey Yeer)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, fectory, offica building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physicien:** To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the besis of exemination end/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) end menner stated.

29b. Signeture end title of certifier: A.H. Ghiladi
29c. License number: O-0012849
29d. Date signed (Month, Dey, Yeer): 12-7-98

30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print): A.H. GHILADI, MD 7600 OSLER Dr. TOWSON. Md. 21204

State Registrar

31. Dete filed (Month, Day, Year): DEC 07 1998
32. Registrar's Signature: Barbara G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

WR 6

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item: #26,30 Per MD Film G766 12-7-98RC

Certificate of Death

Reg. No. 98 37371

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Gerard A. Budzynski
2. Date of Death — Month: November Day: 30 Year: 1998
3. Time of Death: 0428AM
4a. Facility Name (If not institution, give street and number): Franklin Square Hospital
4b. City, Town, or Location of Death: Rosedale
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 217-38-7066
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 56 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 13, 1942
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Rosedale
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 1515 Customs Road
10f. Zip Code: 21237
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Computer Specialist
16b. Kind of Business/Industry: US Government

17. Father's Name (First, Middle, Last): Andrew Budzynski
18. Mother's Name (First, Middle, Maiden Surname): Anna Birner

19a. Informent's Name/Relationship (Type, Print): Regina M. Budzynski/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1515 Customs Rd. Rosedale, Maryland 21237

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Holy Rosary Cemetery
Date: 12/4/98
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Kathleen Weber CFSP
22. Name and Address of Facility: David J. Weber Funeral Homes 401 S. Chester St. Baltimore, Maryland 21231

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Severe Pulmonary Hypertension — 6 months
Due to (or as a consequence of):
b. Prior Pulmonary Embolism — 6 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Coronary Artery Disease, Insulin-Dependent Diabetes Mellitus, Chronic Atrial Fibrillation, Congestive Heart Failure

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☒ ~~Residence~~ 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ [signature]
29c. License number: D40609
29d. Date signed (Month, Day, Year): 12/2/98
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 1005 No. Point Blvd - Suite 700, Baltimore, MD 21224 JANICE RYDEN, MD?

State Registrar

31. Date filed (Month, Day, Year): DEC 07 1998
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached to use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37372

Amended #23b,24a,25,26,27,29a per Phy G766 12/7/98EW

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month Day Year)	3. Time of Death
Lillian Helen Biernacki	November 16, 1998	10:18 p.m.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Memorial Hospital & Medical Center	Cumberland	Allegany

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-46-9440	1☐ M 2☒ F	49 Yrs.			Jan. 8, 1949	Maryland

Usual Residence of Decedent

10e. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Allegany	Cumberland	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
48 Boone Street	21502	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced	unknown 1☐ Yes 2☐ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
7	0	Waitress	Food Service

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Lee F. Benjamin	unknown

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Brenda Osborne/daughter	unknown

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other (Specify) in state			

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Ronald S. Wade, Director	State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Aspiration pneumonia	3 days
Due to (or as e consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Ascites	2 years
Due to (or as a consequence of):		
	c. Nutritional cirrhosis	10 years
Due to (or as e consequence of):		
	d. Alcohol abuse	30 years

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Post peritoneovenous shunt

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Fred W. Miltenberger, M.D.	D 14393	November 17, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Frederick Miltenberger, M.D., Johnson Height Medical Building, Cumberland, MD 21502

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 07 1998	▶ Penny G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Lillian Biernacki
212-46-9440

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37373

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Margaret E. Brown
2. Data of Deeth Month / Day / Yeer: 11/23/98
3. Time of Deeth: 1:00 AM
4a. Fecility Name *(If not institution, give street end number)*: 6117 Moyer Avenue
4b. City, Town, or Location of Death: Baltimore
4c. County of Deeth: N/A

Funeral Director

5. Social Security Number: 219-16-3687
6. Sex: 1☐ M 2☒ F
7. Aga *(In yrs. last birthdey)*: 85 Yrs. — If Under 1 Yeer: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Yeer)*: 9/29/1913
9. Birthpleca *(Stete or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street end Number: 5101 Eugene Avenue
10f. Zip Code: 21206
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Naver Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forcas? 1☐ Yas 2☒ No — If Yes, Give Year or Datas:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puerto Rican, atc.): 1☐ Yes 2☒ No *Specify:*
14. Race - Americen Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highast grada completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usuel Occupation *(Giva kind of work dona during most of working life. DO NOT use retired)*: Switch Board
16b. Kind of Business/Industry: Shepherd Pratt

17. Fether's Neme *(First, Middle, Last)*: Milton Oliver Fester
18. Mother's Neme *(First, Middle, Meiden Surneme)*: Margaret Mae Thompson

19a. Informant's Name/Relationship *(Type, Print)*: Eugene J. Brown/Grandson
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 6117 Moyer Avenue Baltimore, Maryland 21206

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from Stata 4☐ Donation 5☐ Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, cremetory or other place)*: Woodlawn Cemetery
Dete: 11/25/98
20c. Location - City or Town, Stete: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Juanita R Thomas
22. Nama end Address of Fecility: John C. Miller inc. 6415 Belair Road Baltimore, Maryland 21206

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the moda of dying, such es cerdiac or raspiretory errest, shock, or heart failure. List only one cause on each line.

Approximate Intervel Between Onset end Daath

Immediate Cause (Final disease or condition resulting in death)
e. Malignant Biliary Obstruction — 2month
Due to (or as e consequence of):
b. Mass in the Ampulla of Vater
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Sequentially list conditions, if eny, leading to immadiate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco uee contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was cese referred to medicel examiner? 1☐ Yes 2☒ No

26. Place of Deeth *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* Grand Sns Home

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end piece, end due to the ceuse(s) end menner as stated. 2☐ **Medical Examiner:** On the besis of examination end/or investigation, in my opinion, deeth occurred et the time, date and piece, and due to the ceuse(s) end menner stated.

29b. Signature and title of certifier: MD
29c. Licensa number: D25205
29d. Data signed *(Month, Dey, Yeer)*: December 4, 1998

30. Neme end eddress of person who completed ceuse of deeth (Item 23a) (Type, Print): W. A. Riley GBMC 6701 N. Charles St Balto. MD 21204

State Registrar

31. Date filed *(Month, Day, Yeer)*: DEC 07 1998
32. Registrer's Signeture: B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours efter death with the Marylend Department of Health end Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

R&U 10

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 37374

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: WALTER A. CAMPBELL
2. Dete of Deeth — Month: DECEMBER, Day: 6, Year: 1998
3. Time of Death: 1.38 PM
4a. Facility Name *(If not institution, give street and number)*: North Arundel Hospital
4b. City, Town, or Location of Deeth: Glen Burnie
4c. County of Deeth: Anne Arundel

Funeral Director

5. Social Security Number: 198-18-9204
6. Sex: 1☐M 2☐F — X
7. Age *(In yrs. last birthday)*: 73 Yrs.
If Under 1 Year: Months / Deys
If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Dey, Year)*: JULY 12, 1925
9. Birthplece *(Stete or Foreign Country)*: PENNSYLVANIA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ANNE ARUNDEL
10c. City, Town or Location: GLEN BURNIE
10d. Inside City Limits: 1☐Yes 2☒No — X
10e. Street end Number: 7727 MARBROOK ROAD
10f. Zip Code: 21060
10g. Citizen of Whet Country?: UNITED STATES

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced — X
12. Wes Decedent Ever in U.S. Armed Forces?: XXYes 2☐No — If Yes, Give Year or Dates: '43-'46
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐Yes 2XXNo *Specify:*
14. Race - Americen Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grede completed)*: Elementary/Secondary (0-12); College (1-4or 5+): 1
16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: RADIO OPERATOR
16b. Kind of Business/Industry: AIRLINE

17. Fether's Name *(First, Middle, Last)*: WALTER A. CAMPBELL, SR.
18. Mother's Name *(First, Middle, Maiden Surneme)*: MARTHA DEITSCHE

19a. Informant's Name/Relationship *(Type, Print)*: DIANE L. CAMPBELL
19b. Mailing Address *(Street and Number or Rurel Route Number, City or Town, State, Zip Code)*: 7727 MARBROOK RD. GLEN BURNIE, MD 21060

20e. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*
20b. Place of Disposition *(Neme of cemetery, crematory or other piece)*: CROWNSVILLE MD VET. CEM. — Date: DEC. 9, 1998
20c. Location - City or Town, State: CROWNSVILLE, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Fecility: KIRKLEY-RUDDICK FUNERAL HOME, 421 CRAIN HWY. S.E. GLEN BURNIE, MD 21061

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heart failure. List only one cause on eech line.

Approximete Intervel Between Onset end Death

Immediate Cause (Final disease or condition resulting in death)
a. End Stage Renal Disease — Approximete Intervel Between Onset end Death: 1 YEAR
Due to (or es e consequence of):
b. Multiple Myeloma
Sequentially list conditions, if eny, leading to immedeite ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest
Due to (or as e consequence of):
c.
Due to (or as e consequence of):
d.

Part II. **Other significent conditione** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cauee of death? 1☐Yes 2☐No 3☐Probably 4☐Unknown

24a. Was en autopsy performed? 1☐Yes 2☑No
24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 1☐Yes 2☐No

25. Wes case referred to medical examiner? 1☐Yes 2☑No

28. Piece of Death *(Check only one)*: Hospitel: 1☑Inpatient 2☐ER/Outpatient 3☐DOA — Other: 4☐Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Manner of Deeth: 1☑Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury et Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rurel Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑**Certifying Phyaicien:** To the best of my knowledge, death occurred at the time, date end piece, end due to the ceuse(s) end menner es steted. 2☐**Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and place, end due to the cause(s) end menner stated.

29b. Signature end title of certifier: [signature] MD
29c. License number: #D51245
29d. Date signed *(Month, Dey, Year)*: DECEMBER 6, 1998

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print): SAJID SHARIF NORTH ARUNDEL HOSPITAL-MD

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 07 1998
32. Registrer's Signature: Jenna G. Sparks

DHMH 16 Rev 6/95

Campbell, Walter

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

15

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37375

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James Lester Carvell
2. Date of Death: Month November Day 30 Year 1998
3. Time of Death: 10:26 a.m.
4a. Facility Name (If not institution, give street and number): Lorien Frankford Nursing & Rehabilitation Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 214-22-3626
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 70 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): February 22, 1928
9. Birthplace (State or Foreign Country): Mifflin, Pa.

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore City
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 4600 Frankford Avenue
10f. Zip Code: 21206
10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [XX] Yes 2 [ ] No If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Forklift Operator
16b. Kind of Business/Industry: U.S. Gypson

17. Father's Name (First, Middle, Last): Cloyd Elvin Carvell
18. Mother's Name (First, Middle, Maiden Surname): Lauretta Salina Fulkrote

19a. Informant's Name/Relationship (Type, Print): Virginia Carvell
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 615 S. Market St. Selings Grove, Pa. 17870

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Westminster Pres. Cem. Date: December 4, 1998
20c. Location - City or Town, State: Juniata, Pa.

21. Signature of Funeral Service Licensee: Heather Lassahn Chojnacki
22. Name and Address of Facility: Lassahn Funeral Home, 7401 Belair Road Baltimore, Maryland 21236-4625

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): e. OROPHARYANGEAL CA
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Dysphagia
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [✓] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier
29c. License number: D 52739
29d. Date signed (Month, Day, Year): 12/02/98
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Suresh Shandelya, 5009 Frankford Ave.

State Registrar

31. Date filed (Month, Day, Year): DEC 07 1998
32. Registrar's Signature: S. Sparks

DHMH 16 Rev 6/95

James Carvel
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

98 37376

Reg. No.

AMENDED #23a pt1B PER Phy G766 12/07/98 EW

Ann Jeanette Casper

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Dete of Deeth Month / Dey / Yeer	3. Time of Deeth
Anne	Jeanette	Casper	NOVEMBER 1 1998	12:30 a.m.

4e Feciity Neme (If not institution, give street end number)	4b. City, Town, or Location of Deeth	4c. County of Deeth
GREATER BALTIMORE MEDICAL CENTER TOWSON	TOWSON	BALTIMORE

Funeral Director

5. Sociel Security Number	6. Sex	7. Age (In yrs. last birthdey)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Dey, Yeer)	9. Birthplace (State or Foreign Country)
217-24-5370	1☐ M 2☒	74 Yrs.			Sept. 8 1924	Maryland

Usuel Residence of Decedent

10e. Stete	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Baltimore	Cockeysville	1☐ Yes 2☒ No

10e. Street end Number	10f. Zip Code	10g. Citizen of Whet Country?
10909 York Rd.	21030	USA

11. Marital Status	12. Was Decedent Ever in U,S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.)	14. Rece - Americen Indien, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Yeer or Detes:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grede completed)		16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondery (0-12)	College (1-4or 5+)		
10	n/a	Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Sumeme)
Edward Gill	Mary Tracy

19a. Informent's Name/Reletionship (Type, Print)	19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)
George W. Casper, Sr./Husband	10909 York Rd., Cockeysville, MD 21030

20a. Method of Disposition	20b. Piece of Disposition (Neme of cemetery, cremetory or other piece)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)	Dulaney Valley Memorial Gardens	11/3/98	Timonium, MD 21093

21. Signeture of Funeral Service Licensee	22. Name and Address of Feciility
Lowell M. Lemmon	Lemmon Funeral Home 10 W. Padonia Rd., Timonium, MD 21093

Physician /Medical Examiner

23a. Part I. Enter the disease, or complicetions that ceused the death. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line.

		Approximate Intervel Between Onset end Deeth
Immediate Cause (Final disease or condition resulting in death)	e. CARDIO PULMONARY ARREST	< 1/2 Hour
	Due to (or es e consequence of):	
Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury thet initiated events resulting in death) Lest	b. HISTORY OF HYPERTENSION	
	Due to (or es e consequence of):	
	c.	
	Due to (or es e consequence of):	
	d.	

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying ceuse given in Pert I.

23b. Did tobacco use contribute to the cauee of death?	24a. Wes en eutopsy performed?	24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth?
1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown	1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Wes case referred to medical examiner?	26. Piece of Death (Check only one)	
1☐ Yes 2☒ No	Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☒ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28e. Dete of Injury (Month, Dey Yeer)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one)
1☒ **Certifying Physician**: To the best of my knowledge, death occurred et the time, date end piece, end due to the ceuse(s) end menner es steted.
2☐ **Medical Examiner**: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the ceuse(s) and manner stated.

29b. Signeture end title of certifier	29c. License number	29d. Date signed (Month, Dey, Yeer)
MD	050232	November 1, 1998

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)
CYRUS HAMIDI, MD 3346 PAPER MILL RD Phoenix MD 21131

State Registrar

31. Date filed (Month, Day, Year)	32. Registrer's Signeture
DEC 07 1998	Denise G. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

98-6962-510
crn
Martin Stewart Cook

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37377

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Martin Stewart Cook
2. Date of Death (Month, Day, Year): November 30, 1998
3. Time of Death: 5:07 P.M.
4a. Facility Name (If not institution, give street end number): 1426 North Fulton Avenue
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-58-3649
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 47 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 21, 1951
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☐ Yes 2 ☐ No
10e. Street end Number: 1530 N. Gilmore Street
10f. Zip Code: 21217
10g. Citizen of What Country? U.S.A

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 1
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Pipefitter
16b. Kind of Business/Industry: Plumbing

17. Father's Name (First, Middle, Last): Joseph R. Cook
18. Mother's Name (First, Middle, Maiden Surname): Elizabeth Figueroa

19a. Informant's Name/Relationship (Type, Print): Joseph R. Cook - father
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 101 N. Smallwood St, Baltimore MD 21223

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Mt. Zion
Date: December 9, 1998
20c. Location - City of Town, Stete: Baltimore, MD

21. Signature of Funeral Service Licensee: Carlton R. Douglass
22. Name end Address of Facility: Douglass Funeral Service 1201 McCulloh St, Baltimore, MD 21217

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Ceuse (Final diseese or condition resulting in death): e. Multiple Injuries
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that Initieted events resulting in death) Lest
b. Due to (or es a consequence of):
c. Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Wes an eutopsy performed? 1 ☒ Yes 2 ☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☒ Yes 2 ☐ No

25. Wes case referred to medical examiner? ☒ Yes 2 ☐ No
26. Place of Deeth (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) at scene

27. Menner of Deeth: 1 ☐ Neturel 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year): 11/27/98
28b. Time of Injury: 1637 Hr M
28c. Injury at Work? 1 ☐ Yes 2 ☒ No
28d. Describe how injury occurred: Subject pedestrian struck by motor vehicle
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Roadway
28f. Location (Street and Number or Rural Route Number, City or Town, State): 1426 North Fulton Avenue Baltimore Maryland

29e. Certifier (Check only one): 1 ☐ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) end menner as stated. 2 ☒ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) and manner stated.

29b. Signeture end title of certifier: Theodore M. Kiyasu
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): December 01, 1998

30. Neme end eddress of person who completed cause of death (Item 23a) (Type, Print): THEODORE M. Kiyasu 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed (Month, Day, Year): DEC 07 1998
32. Registrer's Signeture: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 37378

Item#17 per FH G766 12/07/98 EW

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Rawleigh J. Cousar

2. Dete of Death: Month December Day 2 Year 1998

3. Tima of Death: 1012 AM

4e. Facility Nama (If not institution, give street and number): MARYLAND GENERAL HOSPITAL

4b. City, Town, or Location of Deeth: BALTIMORE CITY

4c. County of Deeth:

Funeral Director

5. Social Security Number: 247-62-0914

6. Sax: 1 [X] M 2 [ ] F

7. Aga (In yrs. last birthday): 58 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): 10 08 40

9. Birthplaca (Stata or Foreign Country): S.C.

Usual Residanca of Dacedent

10a. Stata: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Insida City Limits: 1 [X] Yas 2 [ ] No

10e. Street and Number: 4637 Park Heights Ave, Apt 103

10f. Zip Coda: 21215

10g. Citizan of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedant Evar in U,S. Armed Forcas? 1 [ ] Yas 2 [X] No If Yas, Giva Year or Dates:

13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 1 [ ] Yas 2 [X] No Specify:

14. Race - American Indien, Black, Whita, atc. Specify: Black

15. Decedant's Education (Specify only highast grade completed): Elamentary/Secondary (0-12): 12th grade; Collega (1-4or 5+): N/A

16a. Decedant's Usual Occupation (Give kind of work done during most of working lifa. DO NOT usa ratired): Baker

16b. Kind of Businass/Industry: A& P Bakery

17. Fathar's Nama (First, Middle, Last): SAM ~~Miriam~~ Cousar

18. Mothar's Name (First, Middle, Maidan Surname): Queen Esther Coker

19e. Informant's Nama/Ralationship (Type, Print): Miriam Cousar-Wife

19b. Mailing Addrass (Straat and Number or Rural Routa Numbar, City or Town, Stata, Zip Code): 4637 Park Heights Ave Apt 103, Balto Md 21215

20a. Mathod of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Ramoval from Stata 4 [ ] Donation 5 [ ] Othar (Specify)

20b. Placa of Disposition (Nama of camatary, cramatory or othar placa): King Memorial Park

Data: 12/7/98

20c. Location - City or Town, State: Randallstown, Md

21. Signatura of Funaral Sarvica Licensaa: Gabrielle Cook

22. Nama and Addrass of Facility: March F/H West 4300 Wabash Ave, Baltimore Md 21215

Physician /Medical Examiner

23a. Part1. Enter tha disaese, or complicetions that causad the daath. Do not antar the mode of dying, such es cardiac or raspiratory arrest, shock, or heart failure. List only ona causa on each lina.

Approximata Intarval Between Onsat and Death

Immediata Ceusa (Final disease or condition rasulting in daath)

a. Respiratory / Cardiac Failure

Dua to (or as a consequance of):

b. Stage IV Cancer of Esophagus Metastatic

Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Cause (Disaasa or Injury that initiated avants rasulting in daath) Last

Dua to (or as a consaquanca of):

c. Squamous Cell Cancer of Larynx

Due to (or as a consaquance of):

d.

Part II. **Other significant conditions** contributing to daath but not resulting in tha underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an autopsy performed? 1 [ ] Yas 2 [✓] No

24b. Ware autopsy findings availabla prior to compliation of causa of daath? 1 [ ] Yes 2 [ ] No

25. Was casa rafarrad to medical examinar? 1 [ ] Yas 2 [✓] No

26. Placa of Daath (Check only one)

Hospital: 1 [✓] Inpatiant 2 [ ] ER/Outpatiant 3 [ ] DOA

Othar: 4 [ ] Nursing Homa 5 [ ] Rasidanca 6 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accidant 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Pending investigation 6 [ ] Could not be datarminad

28e. Data of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yas 2 [ ] No

28d. Describe how injury occurred

28a. Placa of Injury - At homa, farm, street, factory, offica building, atc. (Spacify)

28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

29a. Cartifiar (Check only one): 1 [✓] **Certifying Phyaician:** To tha bast of my knowledga, daath occurrad at the time, dete end place, and dua to tha causa(s) and manner es steted. 2 [ ] **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at tha tima, data and placa, and due to the ceuse(s) and mannar stated.

29b. Signatura and titla of cartifiar: Gil, M.D.

29c. Licansa number: P12671

29d. Date signad (Month, Day, Yaar): 12/2/98

30. Nama and addrass of parson who completad causa of daath (Item 23a) (Type, Print): Elisa Gil, M.D. C/O Maryland General Hospital

State Registrar

31. Data filad (Month, Day, Yaar): DEC 07 1998

32. Registrar's Signatura: Geneva B. Sparks

DHMH 16 Rev 6/95

Rawleigh Cousar

Baltimore, Maryland 21215-0020

permit. Pagas 1 and 2 should be filed within 72 hours after death with tha Maryland Department of Haalth and Mantal Hygiana. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: Tha law requiras that tha daath cartificata be executed within 24 hours after death.

To the Funeral Director: After this cartificata has been signed by the attanding physician and compliataly filled in by tha funaral director, page 2 should ba datached for usa as tha burial-transit

98-7061-510
B.K.S

OTIS CARTER

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 37379

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Dey Year	3. Time of Death
OTIS CARTER	DEC. 3, 1998	1427 PM

4e Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
4505 FINNEY AVENUE	BALTIMORE	NA

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
247-34-6462	1☒M 2☐F	70 Yrs.			Oct. 3 1928	S.C.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	NA	BALTIMORE	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
4505 FINNEY AVENUE	21215	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates: 10/45 6/47	1☐Yes 2☒No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
4th	NA	LABORER	BETHLEHEM STEEL

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
WALLACE HOLLY	RUTH CARTER

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
IDA CARTER - WIFE	4505 FINNEY AVE BALTIMORE, MD 21215

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	METRO CREMATORY	12-8-98	BALTIMORE, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Thomas B. Harris	MARCH FUNERAL HOME WEST, INC. 4300 WABASH AVE. BALTO., MD 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Intra-Oral Gunshot Wound

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒Yes 2☐No	1☒Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
☒Yes 2☐No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐Natural 2☐Accident 3☒Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined	Found 12-3-98	Found 1420 p M	1☐Yes 2☒No	self inflicted gunshot wound

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): home

28f. Location (Street and Number or Rural Route Number, City or Town, State): 4505 Finney Ave Baltimore, Md

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Dennis J. Chudzew	O.C.M.E	DEC. 4, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dennis J. Chudzew 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 07 1998	Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37380

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Esther L. Cox

2. Date of Death (Month, Day, Yeer): December 2, 1998

3. Time of Death: 11:30am

4a. Facility Neme (If not institution, give street end number): 1203 West Lake Avenue

4b. City, Town, or Location of Deeth: Mt. Washington

4c. County of Death: Baltimore Co

Funeral Director

5. Social Security Number: 218-32-0326

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. lest birthday): 64 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct 10, 1934

9. Birthplece (Stete or Foreign Country): Maryland

Usual Residence of Decedent

10e. State: Maryland

10b. County: Baltimore Co

10c. City, Town or Location: Mt. Washington

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1203 West Lake Avenue

10f. Zip Code: 21210

10g. Citizen of Whet Country?: U.S.A

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Ricen, etc.): 1☐ Yes 2☒ No Specify:

14. Race - Americen Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed): Elementary/Secondary (0-12): 10 | College (1-4or 5+):

16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Home Maker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): William Presley Wilson

18. Mother's Name (First, Middle, Maiden Surname): Ruth Naomie Joy

19a. Informant's Name/Reletionship (Type, Print): Roland Cox, Jr. (Son)

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 116 Ridge Avenue, Tawneytown, Maryland 21787

20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other piece): Evergreen Mem. Park

Dete: 12/4/98

20c. Locetion - City or Town, State: Finksburg, Maryland

21. Signature of Funeral Service Licensee: ▶ A. Alan Seitz Jr

22. Name end Address of Facility: A. Alan Seitz, Jr. Funeral Home, 3818 Roland Avenue, Baltimore, Maryland 21211

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximete Intervel Between Onset end Death

Immediate Ceuse (Finel disease or condition resulting in death)
e. Adenocarcinoma of Gallbladder
Due to (or es a consequence of):

Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Lest
b.
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other signifiicent conditions** contributing to death but not resulting in the underlying ceuse given in Part I.
ASCVD.

23b. Did tobacco use contribute to the cauee of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? 1☐ Yes 2☒ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Yeer)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end manner es steted. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) and menner stated.

29b. Signature end title of certifier: ▶ Betsy A. Fay MD

29c. License number: D33220

29d. Date signed (Month, Day, Yeer): 12/3/98

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print): Betsy A. Fay, M.D. 3730 Falls Rd. Baltimore, Maryland 21211

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Dete filed (Month, Day, Yeer): DEC 07 1998

32. Registrer's Signature: G. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37381

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Leonard Chubb
2. Dete of Death: Month 12 Dey 2 Yeer 1998
3. Time of Death: 9.24 PM
4e. Feciility Neme (If not institution, give street and number): Johns Hopkins Geriatrics Center - Johns Hopkins Bayview Medical Center
4b. City, Town, or Location of Deeth: Baltimore
4c. County of Death:

Funeral Director

5. Social Security Number: 185-24-7619
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 69 Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Day, Year): April 4, 1929
9. Birthplece (State or Foreign Country): Pa.

Usuel Residence of Decedent

10e. State: Md.
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street end Number: 15 Rodman Way
10f. Zip Code: 21205
10g. Citizen of What Country?: USA
11. Marital Stetus: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Rece - Americen Indien, Bleck, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12 yrs. College (1-4or 5+):
16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Paint Shader
16b. Kind of Business/Industry: Valspar
17. Fether's Neme (First, Middle, Last): Dewey Chubb
18. Mother's Name (First, Middle, Maiden Surname): Carrie Loomis
19e. Informent's Neme/Reiationship (Type, Print): Patricia Chubb wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 15 Rodman Way Baltimore Md. 21205
20e. Method of Disposition: 1 [ ] Buriel 2 [X] Cremation 3 [ ] Removel from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Pleca of Disposition (Name of cemetery, cremetory or other place): Metro Crematory
Dete: 12-5
20c. Location - City or Town, Stete: Baltimore
21. Signature of Funeral Service Licensee:
22. Name end Address of Feciility: Connelly Funeral Home Of Dundalk 7110 Sollers Point Rd. 21222

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Pert I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line.

Approximete Intervel Between Onset end Deeth

Immediete Ceuse (Finel disease or condition resulting in deeth): e. Aspiration Pneumonia — 3 days

Due to (or es e consequence of):

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in death) Lest:

b.

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Pert II. **Other elgnificant conditione** contributing to death but not resulting in the underlying cause given in Pert I.: Stroke, myeloproliferative Disease, Hypatension, Type 2 Diabetes

23b. Did tobacco uee contribute to the cauee of death? 1 [ ] Yes 2 [✓] No 3 [ ] Probably 4 [ ] Unknown

24e. Wes en eutopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1 [ ] Yes 2 [✓] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Deeth (Check only one): Hospitel: 1 [ ] Inpetient 2 [ ] ER/Outpetient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [✓] Other (Specify) chronic hospital

27. Manner of Deeth: 1 [✓] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year):
28b. Time of Injury:
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred:
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify):
28f. Location (Street and Number or Rural Route Number, City or Town, State):

29e. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the ceuse(s) end menner es steted. 2 [ ] **Medical Examiner:** On the basis of exemineticn end/or Investigetion, in my opinion, death occurred et the time, dete end placa, end due to the ceuse(s) end menner stated.

29b. Signeture end title of certifier: M.D.
29c. License number: D0052104
29d. Date signed (Month, Day, Year): December 3, 1998

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print): Timothy Lee 5505 Hopkins Bayview circle, Baltimore, maryland 21224

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

31. Date filed (Month, Day, Year): DEC 07 1998
32. Registrer's Signeture: Geneva G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriel-transit

3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item:17per F.H G-766 12/7/98 reb

Certificate of Death

Reg. No. 98 37382

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Dey Yeer	3. Time of Death
DOROTHY L. CUNNINGHAM	DECEMBER 4, 1998	8:30 A.M.

4a Facility Neme (If not institution, give street end number)	4b. City, Town, or Location of Death	4c. County of Deeth
HOSPICE OF BALTIMORE AT GILCHRIST CENTER	TOWSON	BALTIMORE COUNTY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Deys	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Dey, Yeer)	9. Birthplace (State or Foreign Country)
21928-2730	1☐ M 2☒ F	79 Yrs.					May 5, 1919	Virginia

Usuel Residance of Decedent

10a. Steta	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore County	Carney	1☐ Yes 2☒ No

10e. Street end Number	10f. Zip Code	10g. Citizen of Whet Country?
3016 Second Avenue	21234	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Merried 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Educetion (Specify only highest grede completad)		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry UNKNOWN
Elementary/Secondary (0-12)	Collega (1-4or 5+)		
Unk		Factory Worker	

To Be Completed by Funeral Director

17. Fether's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
~~William Schmidbauer~~ Ghorley Hatcher	Pauline Morris

19a. Informent's Neme/Raletionship (Type, Print)	19b. Mailing Addrass (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)
William Schmidbauer	9431 Belair Road, Baltimore, Maryland 21236

20e. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other place)	Dete	20c. Location - City or Town, State
1☐ Burial 2☒ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)	Green Mount Crematory		Baltimore, Maryland

21. Signeture of Funeral Service Licensee	22. Name and Address of Facility
Robert C. Altenburg	Altenburg Funeral Home, P.A. 6009 Harford Road, Baltimore, Maryland 21214

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the diseese, or complications thet caused the death. Do not enter the mode of dying, such es cerdiac or respiratory errest, shock, or heert failure. List only one ceuse on eech lina.

		Approximata Intarval Between Onset and Daath
Immediate Cause (Final disaasa or condition resulting in death)	a. end-stage Parkinson's Disease	years
	Due to (or es e consaquence of):	
Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Ceusa (Disaasa or Injury thet initiated events resulting in deeth) Lest	b.	
	Dua to (or as e consaquance of):	
	c.	
	Due to (or as e consequence of):	
	d.	

Pert II. **Other eignificent conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings eveileble prior to completion of cause of daeth?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was casa rafarrad to medical examiner?	26. Plece of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice

27. Mannar of Death	28a. Date of Injury (Month, Day Year)	28b. Tima of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Panding investigation 6☐ Could not be datarmined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, straet, factory, office building, atc. (Specify)			28f. Location (Streat and Number or Rurel Route Number, City or Town, Stata)

29a. Certifier (Check only one)	
1☒ Certifying Physician: To tha best of my knowledga, daeth occurred at the time, date and place, and due to the ceuse(s) and manner as stated.	
2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and dua to the ceusa(s) and manner stated.	

29b. Signeture and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
W. Anthony Riley, MD	D25205	December 4, 1998

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)
W.A.R.Ley GBMC 6701 N. Charles St Balto. MD 21204

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 07 1998	D. Hunter

To the Hospital or Attending Physician: The law requires thet the deeth certificate be executed within 24 hours efter death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Cunningham, Dorothy December 4, 1998 8:31am

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 37383

Item:23 part I, per M.D G-766 12/7/98 reb

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Joan Casler

2. Dete of Deeth: Month Nov. Dey 13, Yeer 1998

3. Time of Deeth: 5:54 P.M.

4e. Feeility Name (If not institution, give street end number): 2901 Cold Spring Way Apt. 426

4b. City, Town, or Location of Death: Crofton

4c. County of Deeth: Anne Arundel

Funeral Director

5. Social Security Number: 137 44 8306

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 86 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Dey, Yeer): Feb. 11,1912

9. Birthpleee (Stete or Foreign Country): Brantford,Ontario

Usual Residence of Decedent

10a. Stete: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Crofton

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 2901 Cold Spring Way Apt. 426

10f. Zip Code: 21114

10g. Citizen of Whet Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Edeetion (Specify only highest grede completed): Elementery/Secondary (0-12): 12; College (1-4or 5+): 1

16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Missionary

16b. Kind of Business/Industry: Foreign Mission Work

17. Fether's Neme (First, Middle, Last): John MacDonald

18. Mother's Name (First, Middle, Maiden Surneme): Mary Hodge

19a. Informent's Name/Relationship (Type, Print): Douglas Casler Son

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 1832 Harewood Lane Crofton Maryland 21114

20e. Method of Disnoltion: 1☐ Burial 2☒ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other piece): The Huntt Crematory Dete: Nov. 18, 1998

20c. Location - City or Town, State: Waldorf Maryland

21. Signeture of Funeral Service Licensee: Todd Liller

22. Neme end Address of Feeility: Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heart failure. List only one cause on eech line.

Approximete Interval Between Onset end Death

Immediate Ceuse (Finel diseese or condition resulting in death): e. CARDIAC ARRHYTHMIA ~~Sudden Death Possible Cardiac~~

Due to (or es e consequence of): a. atherosclerosis — Several years.

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest

Due to (or es e consequence of): b.

Due to (or es e consequence of): c.

d.

Pert II. **Other elgnificent conditione** contributing to death but not resulting in the underlying ceuse given in Pert I. Osteoarthritis

23b. Did tobacco uee contribute to the cause of death? 1☐ Yee 2☑ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☑ No

24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Was cese referred to medical exeminer? 1☐ Yes 2☑ No

26. Place of Deeth (Check only one): Hospital: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Phyeicien:** To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medicel Examiner:** On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the ceuse(s) and manner steted.

29b. Signeture end title of certifier

29c. License number: D14136

29d. Dete signed (Month, Dey, Yeer): 11/14/98

30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print): DALJIT S. SAWHNEY 201 Suite, Crain Towers Glen Burnie md 21061.

State Registrar

31. Dete filed (Month, Dey, Yeer): DEC 07 1998

32. Registrer's Signature: G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours efter death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

98-6908-510
B.K.S

MARY L. DAVIS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37304

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Data of Daeth Month / Day / Yaar	3. Time of Death
MARY L. DAVIS	NOV. 27, 1998	1537 PM

4a Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
444 OXFORD COURT	BALTIMORE	

Funeral Director

5. Social Security Numbar	6. Sax	7. Aga (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Data of Birth (Month, Day, Year)	9. Birthplaca (State or Foreign Country)
214-30-1651	1☐ M 2☒ F	74 Yrs.			05-28-24	MARYLAND

Usual Rasidance of Decedant

10a. Stata	10b. County	10c. City, Town or Location	10d. Insida City Limits
MD	N/A	FREDERICK	1☒ Yas 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizan of What Country?
444 Oxford Court	21217	U.S.A

11. Maritel Status	12. Wes Decedent Evar in U.S. Armed Forces?	13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puerto Rican, atc.)	14. Rece - American Indian, Black, Whita, atc.
1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yas 2☒ No If Yas, Give Yaar or Datas:	1☐ Yas 2☒ No Specify:	Specify: BLACK

15. Decedant's Educetion (Spacify only highast grada complatad)		16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired)	16b. Kind of Businass/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		COSMETOLOGIST	SELF

17. Fathar's Nama (First, Middla, Last)	18. Mother's Nama (First, Middla, Maidan Surname)
UNKNOWN	HELEN CRUMWELL

19a. Informant's Name/Ralationship (Type, Print)	19b. Mailing Addrass (Strast and Number or Rural Route Number, City or Town, State, Zip Code)
VAN A. MEADOWS/Grandson	3611 Windsor Mill Rd. 2ndFl. Balto., Md 21215

20a. Mathod of Disposition	20b. Place of Disposition (Nama of cemetery, cramatory or othar placa)	Data	20c. Location - City or Town, Stata
1☐ Burial 2☒ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Other (Specify)	METRO CREMATORY	12-05-98	Balto,. MD

21. Signatura of Funaral Sarvica Licansaa	22. Nama and Addrass of Facility
Barbara A. [illegible]	William C. Brown Community Funeral Home P.A. 1206 W. North Ave.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that ceusad the daath. Do not antar the moda of dying, such as cerdiac or respiratory arrast, shock, or heart failure. List only ona causa on aach line.

Approximata Intarval Batwaan Onsat and Death

Immediata Causa (Final disaasa or condition rasulting in daath)

a. Hypertensive Arteriosclerotic

Due to (or as a consequence of):

Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Causa (Disaasa or injury that initiated evants rasulting in daath) Last

b. Cardiovascular Disease

Dua to (or as a consaquanca of):

c.

Dua to (or as a consaquanca of):

d.

Part II. **Other significant conditions** contributing to daath but not resulting in tha underlying ceuse givan in Part I.

23b. Did tobacco usa contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performad?	24b. Wara autopsy findings available prior to complation of ceusa of death?
1☒ Yas 2☐ No	1☒ Yas 2☐ No

25. Was case rafarrad to medical examinar?	26. Place of Death (Check only ona)	
1☒ Yas 2☐ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Homa 5☒ Rasidance 6☐ Othar (Specify)

27. Manner of Death	28a. Data of Injury (Month, Day Yaar)	28b. Tima of Injury	28c. Injury at Work?	28d. Dascribe how injury occurred
1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Pending Investigation 6☐ Could not be datarminad		M	1☐ Yas 2☐ No	

28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifier (Check only one)
1☐ **Certifying Physician**: To tha bast of my knowledga, daath occurred at tha tima, data and placa, and due to the ceusa(s) and mannar as stated.
2☒ **Medical Examiner**: On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and placa, and dua to tha causa(s) and mannar stated.

29b. Signatura and title of certifier	29c. Licansa number	29d. Data signad (Month, Day, Year)
[illegible]	O.C.M.E	NOV. 29, 1998

30. Nama and address of parson who completed cause of death (Item 23a) (Type, Print)
Tharon Locke MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Data filed (Month, Day, Year)	32. Registrar's Signatura
DEC 07 1998	[illegible]

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

3
R&D

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37395

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: CHARLES M. DAVIS
2. Date of Death Month / Day / Year: DEC. 5 1998
3. Time of Death: 3:30pm
4a. Facility Name *(If not institution, give street and number)*: 14 Cypress Lane
4b. City, Town, or Location of Death: Middle River
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 235-60-8019
6. Sex: 1☒M 2☐F
7. Age *(In yrs. last birthday)*: 59 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: July 31 1939
9. Birthplace *(State or Foreign Country)*: West Virginia

Usual Residence of Decedent

10a. State: Md.
10b. County: Baltimore
10c. City, Town or Location: Middle River
10d. Inside City Limits: 1☐Yes 2☐No Y
10e. Street and Number: 14 Cypress Lane
10f. Zip Code: 21220
10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Truck Driver
16b. Kind of Business/Industry: Transportation'

17. Father's Name *(First, Middle, Last)*: Charles Davis
18. Mother's Name *(First, Middle, Maiden Surname)*: Violet Pearl DAvis

19a. Informent's Name/Relationship *(Type, Print)*: MArgaret DAvis /Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 14 Cypress Lane Baltimore Md. 21220

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*
20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Holly Hill Cemetery — Date: 12/9/98
20c. Location - City or Town, State: Baltimore Md.

21. Signature of Funeral Service Licensee: ▶ R. Terry Connelly
22. Name and Address of Facility: Connelly Funeral Home of Essex 300 MAce AVe. Baltimore Md.21221

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Acute gastrointestinal hemorrhage
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Chronic ethanol ingestion

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☒Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No
26. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA — Other: 4☐Nursing Home 5☒Residence 6☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☐**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ J. Crossan O'Donovan, M.D.
29c. License number: D07632
29d. Date signed *(Month, Day, Year)*: December 7, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. CROSSAN O'DONOVAN, M.D. 2112 DUNDALK AVE. BALTO MD 21222

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 07 1998
32. Registrar's Signature: Steven G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37306

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HELEN DANIEL

2. Date of Death (Month, Day, Year): NOVEMBER 30 1998

3. Time of Death: 10:04am

4a. Facility Name (If not institution, give street and number): UNIVERSITY OF MARYLAND MEDICAL SYSTEMS

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-36-6131

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 75 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 21, 1923

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 817 Whitelock St.

10f. Zip Code: 21217

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4 or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Stephan Blackwell

18. Mother's Name (First, Middle, Maiden Surname): Helen Jones

19a. Informant's Name/Relationship (Type, Print): Mrs. Virginia Goldsborough (sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5321 Gist Ave. Balto. Md. 21215

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Greenmount Crematory

Date: 12/8/98

20c. Location - City or Town, State: Balto. Md.

21. Signature of Funeral Service Licensee: Joseph L. Russ

22. Name and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Myocardial Infarction

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: P12486

29d. Date signed (Month, Day, Year): 12/1/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Kim R Sing MD 22 South Greene Street Baltimore, MD 21201

State Registrar

31. Date filed (Month, Day, Year): DEC 07 1998

32. Registrar's Signature: D. Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

1

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37367

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
GRADY	CLARK	DAVIS, SR.	NOVEMBER 30, 1998	9:00 A.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
6445 GOLDEN OAK DRIVE	LINTHICUM	ANNE ARUNDEL

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219-26-3218	1☒ M 2☐ F	60 Yrs.			2-10-1938	MARYLAND

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	ANNE ARUNDEL	LINTHICUM	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6445 GOLDEN OAK DRIVE	21090	UNITED STATES

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, atc.)	14. Race - American Indian, Black, White, etc.
1☐ Nevar Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yas 2☒ No If Yes, Give Yaar or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highast grada completed)		16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		INSPECTOR	STATE OF MARYLAND

17. Father's Nama (First, Middla, Last)	18. Mother's Name (First, Middla, Maidan Surnama)
ASA B. DAVIS	ELSIE M. CLARK

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)
CLAUDIA BASCIANO (WIFE)	6445 GOLDEN OAK DRIVE, LINTHICUM, MD 21090

20a. Mathod of Disposition	20b. Piece of Disposition (Nama of cematary, crematory or othar place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cramation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	GLEN HAVEN MEMORIAL PARK	12/3/98	GLEN BURNIE

21. Signature of Funeral Service Licensee	22. Nama and Address of Facility
▶ Paul T. Skeda	SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

Physician /Medical Examiner

23a. Part1. Enter the diseasa, or complications that caused the daath. Do not antar tha moda of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Intervel Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cardio-Pulmonary Arrest	immediate
Due to (or as a consequence of):	b. Widespread Carcinomatosis	4 weeks
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Glioblastoma Multiforme	Sept. 1998
Due to (or as a consequence of):	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

N/A

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☑ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☑ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑ Neturel 2☐ Accident 3☐ Sulcida 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to tha cause(s) and mannar stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	D20938	12/1/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MARIA C. JACOBS, M.D. 419 W. Redwood · Balt., MD 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 07 1998	▶ Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37308

Ebbets Debbie

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Dete of Deeth Month	Dey	Year	3. Time of Deeth
DEBBIE K. EBBERTS	December	4	1998	0700 AM

4e Facility Name (If not institution, give street end number)	4b. City, Town, or Location of Deeth	4c. County of Deeth
NORTH ARUNDEL HOSPITAL	GLEN BURNIE	ANNE ARUNDEL

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. lest birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Dey, Year)	9. Birthplece (Stete or Foreign Country)
215-82-1735	1☐ M 2☒ F	35 Yrs.					APR. 1, 1963	MARYLAND

Usuel Residence of Decedent

10e. Stete	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	ANNE ARUNDEL	SEVERN	1☐ Yes 2☒ No

10e. Street end Number	10f. Zip Code	10g. Citizen of Whet Country?
7204 WB&A RD.	21144	UNITED STATES

11. Marital Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.)	14. Race - American Indien, Bleck, White, etc.
1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grede completed)		16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
0		NONE	NOT APPLICABLE

17. Fether's Neme (First, Middle, Last)	18. Mother's Neme (First, Middle, Maiden Surname)
CALVIN C. EBBERTS	ANNE M. TRAPP

19e. Informent's Name/Relationship (Type, Print)	19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code)
CALVIN C. EBBERTS / FATHER	8204 WB&A. RD., SEVERN, MARYLAND 21144

20e. Method of Disposition	20b. Piece of Disposition (Neme of cemetery, cremetory or other place)	Date	20c. Location - City or Town, Stete
1☒ Burial 2☐ Cremation 3☐ Removel from State 4☐ Donation 5☐ Other (Specify)	MEADOWRIDGE MEM. PK.	DEC. 7 1997	ELKRIDGE, MARYLAND

21. Signature of Funeral Service Licensee	22. Name end Address of Fecility
▶ [signature]	KIRKLEY-RUDDICK FUNERAL HOME, P.A. 421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours efter death with the Meryland Department of Heelth end Mentel Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heert failure. List only one cause on eech line.

		Approximete Interval Between Onset end Death
Immediate Ceuse (Finel diseese or conditlon resulting In death)	e. Pneumonia	1 month
	Due to (or es a consequence of):	
Sequentiellly list conditions, if eny, leading to immediete cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in deeth) Last	b.	
	Due to (or es e consequence of):	
	c.	
	Due to (or as e consequence of):	
	d.	

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

Mental retardation, Seizure disorder

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed?	24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Wes case referred to medical examiner?	26. Piece of Deeth (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Deeth	28e. Dete of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street end Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner es stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, date end piece, end due to the ceuse(s) end menner stated.

29b. Signeture end title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature] MD	D 38958	12/4/98

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

Dafeet Singh Sidhu 1413 ANNAPOLIS ROAD #106 ODENTON MD 21113

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours efter death.
To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, pege 2 should be attached to use as the burial-transit

Division of Vital Records, P.O. Box 68760,

4

State Registrar

31. Dete filed (Month, Day, Year)	32. Registrer's Signature
DEC 07 1998	[signature]

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37309

Physician - /Medical Examiner

1. Decedent's Name (First, Middle, Last): Samuel Elliott

2. Date of Death Month Day Year: December 1 1998

3. Time of Death: 1432

4e. Facility Name (If not institution, give street end number): St. Agnes Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 246-24-2220

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 71 Yrs.

If Under 1 Year Months / Days; If Under 24 Hrs. Hours / Min.

8. Date of Birth (Month, Day, Year): July 14, 1927

9. Birthplace (State or Foreign Country): N. Carolina

Usual Residence of Decedent

10e. State: MD.

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 32 Beaukirt Ave.

10f. Zip Code: 21229

10g. Citizen of What Country? U.S.A

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7th; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Baker

16b. Kind of Business/Industry: Food Chain

17. Father's Name (First, Middle, Last): Paul Elliott

18. Mother's Name (First, Middle, Maiden Surname): Jessey King

19a. Informant's Name/Relationship (Type, Print): Evangeline Elliott

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 32 Beaukirt Ave. Balt. Md. 21229

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): King Mem. Pk. Date: 12/5/98

20c. Location - City or Town, State: Randallstown MD.

21. Signature of Funeral Service Licensee: Gary F. Marchi

22. Name and Address of Facility: Gary F. Marchi Funeral Home P.A. 270 Fredhilton Pass Balt. Md. 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or kidney failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Atherosclerotic heart disease — indefinite

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Peripheral vascular disease

Recent pneumonia

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Sulcide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date and placa, and due to the cause(s) and menner stated.

29b. Signeture and title of certifier: Isadore Feldman, MD

29c. License number: D20676

29d. Date signed (Month, Dey, Year): December 1, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Isadore Feldman. 900 Caton Avenue Baltimore, Maryland 21229

State Registrar

31. Date filed (Month, Day, Year): DEC 07 1998

32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

NAME Samuel Elliott

POS 10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37390

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ALBERT FRANK GALLAS

2. Date of Death (Month, Day, Year): DECEMBER 1, 1998

3. Time of Death: 10:07 AM

4a. Facility Name (If not institution, give street and number): Saint Joseph Medical Center

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 216-03-0590

6. Sex: 1☑ M 2☐ F

7. Age (In yrs. last birthday): 93 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): APRIL 12, 1905

9. Birthplace (State or Foreign Country): PA.

Usual Residence of Decedent

10a. State: MD.

10b. County: BALTIMORE

10c. City, Town or Location: PARKVILLE

10d. Inside City Limits: 1☐ Yes 2☑ No

10e. Street and Number: 2809 GLENDALE AVENUE

10f. Zip Code: 21234

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☑ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementery/Secondary (0-12): 6

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): FOREMAN

16b. Kind of Business/Industry: AUTOMOTIVE

17. Father's Neme (First, Middle, Last): FRANK ALBERT GALLAS

18. Mother's Name (First, Middle, Maiden Surname): ANNA KATHERINE ZUBECK

19a. Informent's Neme/Reletionship (Type, Print): WILLIAM GALLAS, SR, SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 9141 GLENMILL RD. PARKVILLE, MD. 21234

20a. Method of Disposition: 1☑ Buriel 2☐ Cremetion 3☐ Removel from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other piece): PARKWOOD CEMETERY

Dete: DEC. 3, 1998

20c. Location - City or Town, Stete: PARKVILLE, MD.

21. Signature of Funerel Service Licensee

22. Name and Address of Facility: EVANS CHAPEL OF MEMORIES 8800 HARFORD RD. BALTIMORE, MD. 21234

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. SEPSIS — 4 WEEKS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D 30263

29d. Date signed (Month, Day, Year): 12-01-98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): FRANCIS KHOO, M.D., 7620 YORK ROAD, TOWSON, MARYLAND 21204

State Registrar

31. Date filed (Month, Day, Year): DEC 07 1998

32. Registrar's Signature: R. Sparks

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Gallas, Albert

15

98-7060-510
crn
Donald Ray Gosnell

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37391

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Donald Ray Gosnell	December 03, 1998	3:15 P.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
6014 Alta Avenue	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219-82-7382	1☒M 2☐F	36 Yrs.			June 27, 1962	Alabama

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	N/A	Baltimore City	1☒Yes 2☐No

10a. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6014 Alta Avenue	21206	United States

11. Maritel Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indien, Bleck, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Yeer or Dates: 1980-1984	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondery (0-12)	College (1-4or 5+)		
12 yrs.		Printer	Commercial Printing

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
William Gosnell	Teresa Blais

19a. Informant's Name/Reletionship (Type, Print)	19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)
Mrs. Amy C. Gosnell / wife	5419 Pembroke Avenue Baltimore, Maryland 21206

20e. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Dete	20c. Location - City or Town, State
1☐Buriel 2☒Cremetion 3☐Removal from State 4☐Donation 5☐Other (Specify)	Hilltop Service Corp.	12/7/98	Towson, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Fecility
▶ Michael E. Canapp	5305 Harford Road Leonard J. Ruck, Inc. Baltimore, MD 21214

Baltimore, Maryland 21215-0020

permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth end Mentel Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Pert1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heert feilure. List only one cause on eech line.

Approximete Intervel Between Onset end Death

Immediate Cause (Final disease or condition resulting in death)
a. Hanging

Due to (or es a consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Lest
b.
Due to (or es e consequence of):
c.
Due to (or es a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Wes an eutopsy performed? in lieu 1☐Yes 2☒No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Wes case referred to medical examiner? 1☒Yes 2☐No

26. Place of Death (Check only one)
Hospitel: 1☐Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Menner of Death
1☐Natural 2☐Accident 3☒Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined

28a. Dete of Injury (Month, Day Year) Found 12/3/98
28b. Time of Injury 1420 HR
28c. Injury at Work? 1☐Yes 2☒No
28d. Describe how injury occurred Subject hanged self
28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) Home
28f. Location (Street and Number or Rural Route Number, City or Town, State) 6014 Alta Avenue Baltimore Maryland

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner es steted.
2☒ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and plece, end due to the cause(s) end menner steted.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Thomas A. Kingsbury	O.C.M.E.	December 04, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
111 Penn Street, Baltimore, Maryland 21201

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached before using the burial-transit

5+1

State Registrar

31. Dete filed (Month, Dey, Year)	32. Registrar's Signeture
DEC 07 1998	▶ Jenna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37392

GUMP, RALPH

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

1. Decedent's Name *(First, Middle, Last)*: RALPH E. GUMP SR.

2. Data of Death Month Day Yaar: DECEMBER 5, 1998

3. Time of Death: 4:07 PM

4a. Facility Name *(If not institution, giva street and number)*: FRANKLIN SQUARE HOSPITAL CENTER

4b. City, Town, or Location of Death: ROSEDALE

4c. County of Death: BALTIMORE

5. Social Security Number: 235 16 0225

6. Sax: 1☐M 2☐F — X

7. Aga *(In yrs. last birthday)*: 78 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Yaar)*: May 30 1920

9. Birthplaca *(Stata or Foraign Country)*: West Virginia

Usual Residence of Decedant

10a. Stata: Md.

10b. County: Baltimore

10c. City, Town or Location: Essex

10d. Insida City Limits: 1☐Yas 2☒No

10e. Street and Number: 1507 Denton Road

10f. Zip Coda: 21221

10g. Citizan of What Country?: USA

11. Marital Status: 1☐Navar Marriad 2☒Married 3☐Widowad 4☐Divorcad

12. Was Decedant Evar in U.S. Armed Forcas? 1☐Yas 2☒No If Yas, Giva Yaar or Datas:

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 1☐Yas 2☒No *Specify:*

14. Raca - Amarican Indian, Black, Whita, atc. *Specify:* White

15. Dacadant's Education *(Specify only highast grada complatad)*: Elementary/Secondary (0-12): 8th; Collega (1-4or 5+):

16a. Decedent's Usual Occupetion *(Giva kind of work dona during most of working lifa. DO NOT usa ratirad)*: Line Operator

16b. Kind of Businass/Industry: Beth Steel

17. Fathar's Nama *(First, Middla, Last)*: Lindsy Gump

18. Mothar's Nama *(First, Middla, Maidan Sumama)*: Faye Swager

19a. Informant's Name/Ralationship *(Type, Print)*: Rodney Gump / son

19b. Mailing Address *(Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: 10741 Philadelphia Road Perry Hall Md. 21128

20a. Mathod of Disposition: 1☒Burial 2☐Cramation 3☐Ramoval from Stata 4☐Donation 5☐Othar *(Specify)*

20b. Placa of Disposition *(Nama of cematary, cramatory or othar placa)*: Holly Hill Cemetery — Data: 12/8/98

20c. Location - City or Town, Stata: Baltimore Md.

21. Signatura of Funaral Sarvica Licansee: ▶ R. Terry Connelly

22. Nama and Addrass of Facility: Connelly Funeral Home of Essex, 300 Mace AVe. Baltimore Md. 21221

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Entar tha disaasa, or complications that caused the death. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on aach lina.

		Approximata Intarval Batwaen Onset and Death
Immediata Causa (Final disaasa or condition resulting in death) a.	HYPOTENSION	48 HOURS
Dua to (or as a consaquanca of): b.	HYPOXIA	30 MIN.
Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Disaasa or injury that initiated avants rasulting in daath) Last — Dua to (or as a consaquanca of): c.	END STAGE CARDIOMYOPATHY	5 YEARS
Dua to (or as a consaquanca of): d.	ISCHEMIC HEART DISEASE	5 YEARS

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying causa givan in Part I.

PROBABLE SEPSIS

END STAGE CHRONIC OBSTRUCTIVE PULMONARY DISEASE

23b. Did tobacco use contribute to the cause of death? 1☒Yas 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performad? 1☐Yas 2☒No

24b. Wara autopsy findings availabla prior to complation of causa of death? 1☐Yas 2☐No

25. Was case referrad to madical examinar? 1☐Yas 2☒No

26. Placa of Death *(Check only ona)*: Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA; Othar: 4☐Nursing Homa 5☐Rasidanca 6☐Othar *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accidant 3☐Suicida 4☐Homicida 5☐Panding invastigation 6☐Could not be datarmined

28a. Data of Injury *(Month, Day Yaar)*

28b. Time of Injury M

28c. Injury at Work? 1☐Yas 2☐No

28d. Dascribe how injury occurred

28e. Placa of Injury - At home, farm, street, factory, offica building, atc. *(Specify)*

28f. Location *(Streat and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician:** To tha best of my knowledga, daath occurrad at tha tima, data and placa, and dua to the causa(s) and mannar as stated. 2☐**Medical Examiner:** On the basis of axamination and/or invastigation, in my opinion, death occurrad at the time, date and place, and dua to the ceuse(s) and mannar stated.

29b. Signatura and title of cartifiar: ▶ Resident

29c. Licansa number: RD # 188920

29d. Data signed *(Month, Day, Yaar)*: DECEMBER 5, 1998

30. Nama and addrass of parson who completad cause of daath (Item 23e) (Type, Print): PROSPER SANCHEZ MD. 9000 FRANKLIN SQ. DR. BALTO, MD 21237

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

State Registrar

31. Data filad *(Month, Day, Yaar)*: DEC 07 1998

32. Registrar's Signatura: ▶ B. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37393

DARLENE F. HARRIS

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician /Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Darlene F. Harris	November 29, 1998	7:00 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Harbor Hospital Center	Baltimore	

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
473 26 3639	1☐M 2☑F	72 Yrs.			September 11, 1926	Nebraska

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland		Baltimore	1☑Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
509 E. 39th Street	21218	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indien, Black, White, etc.
1☐Never Married 2☐Married 3☑Widowed 4☐Divorced	1☐Yes 2☑No If Yes, Give Year or Dates:	1☐Yes 2☑No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Store Manager	Retail

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Virgil Jackson	Grace Short

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Kathryn Humphreys	6443 Heritage Hill Drive Glen Burnie MD. 21061

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☑Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Garrison Forest Veterans Cemetery	December 7 1998	Garrison, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	Evans Funeral Chapel 8800 Harford Rd. Baltimore MD. 21234

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset end Death
Immediate Cause (Final disease or condition resulting in death)	a. Infiltrating Transitional Cell Carcinoma Bladder	Two Years
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. With Metastasis	
	Due to (or es a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☒Probably 4☐Unknown

24a. Wes an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒Yes 2☐No	1☐Yes 2☒No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☑**Certifying Physician:** To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Rubina Ehtesham (PGY II)	P.11938	November 29, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rubina Ehtesham
3001 South Hanover Street, Baltimore Maryland 21225

State Registrar

31. Date Filed (Month, Day, Year)	32. Registrar's Signature
DEC 07 1998	[signature]

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that this death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

25

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37394

Physician /Medical Examiner

1. Decedent's Nema *(First, Middle, Last)*: Ruth B. Harvey
2. Dete of Deeth — Month: Dec. Day: 6 Yeer: 1998
3. Time of Deeth: 1:15 AM
4a. Facility Nama *(If not institution, giva straat and number)*: Golden Age Guest Home
4b. City, Town, or Location of Daeth: Sykesville
4c. County of Daeth: Carroll

Funeral Director

5. Social Security Number: 233-26-5807
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. lest birthday)*: 83 Yrs. — If Undar 1 Yaar: Months / Deys — If Undar 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Dey, Yeer)*: Jan. 24, 1915
9. Birthplece *(Stete or Foreign Country)*: West Virginia

Usuel Residence of Decedent

10a. State: Maryland
10b. County: Carroll
10c. City, Town or Locetion: Sykesville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 1442 Buckhorn Road
10f. Zip Code: 21784
10g. Citizen of Whet Country?: United States

11. Marital Status: 1☐ Nevar Merried 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedant Evar in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Yeer or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yas, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest greda completed)* — Elementery/Secondery (0-12): 12th — College (1-4or 5+):
16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Cafeteria Supervisor
16b. Kind of Business/Industry: Board of Education

17. Father's Nema *(First, Middle, Last)*: John Beaver
18. Mothar's Nama *(First, Middla, Maidan Surnema)*: Louella Westfall

19a. Informent's Name/Reletionship *(Type, Print)*: Mrs. Karen Rhodes Daughter
19b. Meiling Address *(Street end Number or Rural Routa Number, City or Town, Stete, Zip Code)*: 1016 Klee Mill Road Westminster, MD 21157

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Othar *(Spacify)*
20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Gardens of Faith Cemetery — Date: Dec. 8
20c. Location - City or Town, Stete: Baltimore, Maryland

21. Signature of Funerel Service Licensee: Damon B Corey
22. Name and Address of Facility: Burrier-Queen Funeral Directors, P.A. 1212 W. Old Liberty Road Winfield, MD 21784

Physician /Medical Examiner

23a. Part I. Enter the disaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory errest, shock, or heart failure. List only ona cause on each line. — Approximata Intervel Between Onset end Death

Immediate Ceuse (Final disease or condition resulting in deeth):
e. Primary Degenerative Dementia — >3 yrs

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest:
Due to (or es e consequance of):
b.
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditione** contributing to death but not resulting in tha underlying cause given in Pert I.

23b. **Did tobacco uae contributa to the cause of death?** 1☐ **Yes** 2☑ **No** 3☐ **Probably** 4☐ **Unknown**

24a. Was an eutopsy performed? 1☐ Yas 2☑ No
24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yas 2☑ No

25. Was casa referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Deeth *(Check only one)* — Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA — Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*
27. Menner of Deeth: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)* — 1☑ **Certifying Physicien**: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) end menner es steted. 2☐ **Medicat Examiner**: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) and manner stated.
29b. Signature and title of certifier: Patrick Turnbaugh
29c. Licensa number: D20806
29d. Date signed *(Month, Day, Year)*: 12/7/98
30. Name and eddress of person who completed causa of death (Item 23a) (Type, Print): PATRICK A. TURNBAUGH, MD 1425 LIBERTY RD ELDERSBURG MD

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 07 1998
32. Registrar's Signeture: Jennie G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pagas 1 and 2 should be filed within 72 hours after death with tha Maryland Departmant of Health and Mantal Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: Tha law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has bean signed by the attending physician and completely filled in by tha funeral director, paga 2 should ba detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

4

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37395

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Data of Death Month / Day / Year	3. Time of Death
THOMAS	EARL	HOSTRANDER	DECEMBER 2, 1998	2:30 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
1471 GORDON DRIVE	GLEN BURNIE	ANNE ARUNDEL

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Data of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
166-14-1778	XX 1 M 2 F	77 Yrs.			JAN. 12, 1921	NEW YORK

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	ANNE ARUNDEL	GLEN BURNIE	1 ☐ Yes 2 ☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1471 GORDON DRIVE	21061	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married XX ☒ Widowed 4 ☐ Divorced	XX ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 1942-1946	1 ☐ Yes 2 ☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	N/A	METEOROLOGIST	FEDERAL GOVERNMENT

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
CHARLES HOSTRANDER	BLANCHE BLACKWELL

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
RICHARD EUGENE FRANCIS (NEPHEW)	658 ECHO COVE, CROWNSVILLE, MARYLAND 21032

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
XX ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	MD. VETERANS CEMETERY	12/7/98	CROWNSVILLE, MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Michael C. Taffuri	SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. congestive heart failure	2 years
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. cardiomyopathy	2 years
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No	1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death	28a. Data of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ Yes 2 ☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Stuart Jacobs MD	D 22483	December 4, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Stuart Jacobs MD 203 Hospital Dr. Glen Burnie MD 21061

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 07 1998	▶ Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37396

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): FREDERICK JENKINS
2. Dete of Deeth: Month NOVEMBER Day 26 Yeer 19 98
3. Time of Death: 10:25 Pm
4e. Feciity Name (If not institution, give street end number): FOREST HAVEN NURSING HOME
4b. City, Town, or Location ot Deeth: CATONSVILLE
4c. County of Deeth: BALTIMORE

Funeral Director

5. Social Security Number: 251-62-2473
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 58 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Dey, Yeer): MARCH 7, 1940
9. Birthplace (Stete or Foreign Country): NORTH CAROLINA

Usuel Residence of Decedent

10a. State: MARYLAND
10b. County: BALTIMORE
10c. City, Town or Location: RANDALLSTOWN
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street end Number: 9926 SHOSHONE WAY
10f. Zip Code: 21133
10g. Citizen of Whet Country?: USA.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 11-20-74 / 10-31-78
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Educetion (Specify only highest grade completed): Elementery/Secondary (0-12): 12TH GRADE / College (1-4or 5+)
16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): STAFF SARGEANT
16b. Kind ot Business/Industry: AIR FORCE

17. Father's Name (First, Middle, Lest): SAMUEL JENKINS
18. Mother's Name (First, Middle, Maiden Sumeme): CONSTANCE DOUGLAS

19e. Intorment's Name/Relationship (Type, Print): MARY JENKINS (SISTER-IN-LAW)
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 9926 SHOSHONE WAY, RANDALLSTOWN, MD. 21133

20e. Method ot Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removel from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): CROWNSVILLE CEMETERY
Dete: 12-02-98
20c. Location - City or Town, Stete: CROWNSVILLE, MARYLAND

21. Signeture of Funerel Service Licensee: ▶ [signature]
22. Neme end Address of Facility: JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE. BALTIMORE, MD. 21217

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiretory arrest, shock, or heart tailure. List only one cause on eech line.

Approximete Intervel Between Onset end Death

Immediate Cause (Final diseese or condition resulting in death): e. Esophageal Carcinoma — 10 mths
Due to (or es a consequence of):

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury thet initiated events resulting in deeth) Lest:
b. Due to (or es e consequence of):
c. Due to (or es e consequence of):
d.

Part II. **Other elgnificant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.: Depression

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yee 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24e. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No
24b. Were eutopsy findings eveilable prior to completion of ceuse ot deeth? 1 [ ] Yes 2 [ ] No

25. Was cese referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place ot Deeth (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA; Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner ot Death: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Dete of Injury (Month, Dey Yeer)
28b. Time of Injury
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Piece ot Injury - At home, tarm, street, tectory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physiclen**: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end menner es steted. 2 [ ] **Medicel Examiner**: On the basis ot exeminetion end/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) end menner stated.

29b. Signature end title of certifier: ▶ Geetha Raja MD
29c. License number: DQ7541
29d. Dete signed (Month, Dey, Yeer): December 1, 1998

30. Neme end eddress of person who completed cause ot death (Item 23e) (Type, Print): GEETHA RAJA 4307 Hollins Ferry Rd, Baltimore, MD 21227.

State Registrar

31. Dete filed (Month, Day, Year): DEC 07 1998
32. Registrer's Signeture: [signature]

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

WRC
98-7019-510
VIVIAN
JOHNSON

ITEMS: #6, 7, PER F.H. G767 1-8-99 WR.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

98 37397
Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: VIVIAN JOHNSON
2. Data of Death Month / Day / Year: DECEMBER 02, 1998
3. Time of Death: 9:53 PM.
4a. Facility Name *(If not institution, give street and number)*: JOHNS HOPKINS HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 242 11 0059
6. Sex: 1☐M 2☒F
7. Age *(In yrs. last birthday)*: ~~45~~ 44 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: AUG.14, ~~1953~~ 1954
9. Birthplace *(State or Foreign Country)*: North Carolina

Usual Residence of Decedent

10a. State: MD.
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 1218 PEACHLEAF COURT
10f. Zip Code: 21205
10g. Citizen of What Country?: U.S. OF A.

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): N/A | College (1-4or 5+): N/A
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: NURSE
16b. Kind of Business/Industry: HOME CARE SERVICE

17. Father's Name *(First, Middle, Last)*: LEVON CHERRY
18. Mother's Name *(First, Middle, Maiden Surname)*: EMMA JOHNSON

19a. Informant's Name/Relationship *(Type, Print)*: EMMA L. GRIFFIN (MOTHER)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4007 EDGEWOOD RD. BALTIMORE, MARYLAND 21215

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from Stata 4☐Donation 5☐Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: LOUDON PARK CEMETERY | Data: 12/7/98
20c. Location - City or Town, Stata: BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee: LEWIS T. GWYNN — Lewis T. Gwynn
22. Nama and Address of Facility: LEWIS T. GWYNN FUNERAL HOME 21215-6393, 4517 PARK HEIGHTS AVE. BALTO., MD.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not entar the mode of dying, such es cardiac or raspiratory arrest, shock, or heart failura. List only ona causa on aach line. (Approximata Intarvel Between Onset end Death)

Immediate Cause (Final disease or condition resulting in death): e. Pulmonary Embolus
Dua to (or es e consequence of):
Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☒Probably 4☐Unknown

24a. Was an autopsy performed? 1☒Yas 2☐No
24b. Were autopsy findings available prior to completion of causa of death? 1☒Yas 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No
26. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA | Other: 4☐Nursing Homa 5☐Rasidence 6☐Othar *(Specify)*
27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Data of Injury *(Month, Day Year)*
28b. Tima of Injury
28c. Injury at Work? 1☐Yas 2☐No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, atc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner as steted. 2☒ **Medical Examiner:** On the basis of axamination and/or invastigation, in my opinion, death occurred at tha tima, data and place, and dua to tha cause(s) and mannar stated.
29b. Signature and title of certifier: J. Aaron Locke MD
29c. License number: O.C.M.E.
29d. Data signed *(Month, Day, Year)*: DECEMBER 03, 1998
30. Name and address of person who completed causa of death (Item 23a) (Type, Print): J. CARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 07 1998
32. Registrar's Signatura: Jenna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37398

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Sarah P. Johnson
2. Date of Death Month: 11 Day: 30 Year: 1998
3. Time of Death: 1:50 P.M.
4a. Facility Name *(If not institution, give street and number)*: Caton Manor
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 112-18-0444
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 90 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 3-13-1908
9. Birthplace *(State or Foreign Country)*: VA

Usual Residence of Decedent

10a. State: Md
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street end Number: 6939 Fieldcrest Road
10f. Zip Code: 21215
10g. Citizen of What Country?: U S A

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Yaar or Detas:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 7th grade — College (1-4or 5+): N/a
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Laborer
16b. Kind of Business/Industry: E. R. Sqibb & Son Inc.

17. Father's Name *(First, Middle, Last)*: Milton Coldbourne
18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Dudley

19a. Informent's Neme/Relationship *(Type, Print)*: Eleanor Washington-Niece
19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4423 Ave K Brooklyn, N.Y. 11234-2021

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Ramoval from State 4☐ Donation 5☐ Other *(Specify)*
20b. Piece of Disposition *(Name of cemetery, crematory or other place)*: Arbutus Memorial Park — Date: 12-5-98
20c. Location - City or Town, Stete: Arbutus, Md

21. Signature of Funeral Service Licensee: John B. Johnson Jr.
22. Name end Address of Facility: March F/H West 4300 Wabash Avenue Baltimore, Md 21215

Physician /Medical Examiner

23a. Part I. Enter tha diseasa, or complications that caused the daath. Do not entar tha mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximete Interval Between Onset and Death

Immediate Cause (Final diseese or condition resulting in deeth)
a. Aspiration Pneumonia — 1 day
Due to (or es e consequence of):
b. Cerebrovascular Accident — 3yr

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in death) Lest
Due to (or es a consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Dementia
Emphyseme

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings aveilable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No
26. Place of Deeth *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) and menner as steted. 2☐ **Medical Examiner:** On the besis of exemination and/or investigation, in my opinion, deeth occurred et the time, date end piece, and due to the cause(s) end menner steted.
29b. Signeture and title of certifier: M Rehman MD
29c. License number: D25044
29d. Date signed *(Month, Day, Year)*: 12/1/98
30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print): M. Rehman MD 3800 W. Belvedere Ave Balto, Md 21215

State Registrar

31. Dete filed *(Month, Day, Year)*: DEC 07 1998
32. Registrer's Signeture: P. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37399

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARY R. LINHARD

2. Date of Death (Month, Day, Year): NOV. 29, 1998

3. Time of Death: 11:50 PM

4a. Facility Name *(If not institution, give street and number)*: CHERRYWOOD MANOR NURSING HOME

4b. City, Town, or Location of Death: REISTERSTOWN

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 213-20-4149

6. Sex: 1☐ M 2☑ F

7. Age *(In yrs. last birthday)*: 101 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: MAY 17, 1897

9. Birthplace *(State or Foraign Country)*: MD.

Usual Residence of Decedent

10a. State: MD

10b. County: BALTIMORE

10c. City, Town or Location: LUTHERVILLE

10d. Inside City Limits: 1☐ Yas 2☑ No

10e. Street and Number: 208 RIDGEFIELD ROAD

10f. Zip Coda: 21093

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☑ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yas 2☑ No If Yes, Giva Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.): 1☐ Yas 2☑ No *Specify:*

14. Race - Amarican Indian, Black, Whita, atc. *Specify:* WHITE

15. Decedent's Educetion *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10 | Collega (1-4or 5+):

16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT use retired)*: SUPERVISOR

16b. Kind of Businass/Industry: RETAIL SALES

17. Father's Name *(First, Middla, Last)*: WILLIAM LEIPOLD

18. Mothar's Nama *(First, Middla, Maiden Sumama)*: SARAH O'ROURKE

19a. Informant's Name/Ralationship *(Type, Print)*: SARAH LYNCH, DAUGHTER

19b. Mailing Addrass *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 208 RIDGE FIELD RD. LUTHERVILLE, MD 21093

20a. Mathod of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from Stata 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Nama of cemetary, crematory or othar place)*: BALTIMORE NAT'L. CEMETERY | Data: DEC. 2, 1998

20c. Location - City or Town, Stata: BALTIMORE, MD.

21. Signature of Funaral Service Licensee: Robert W. Evans

22. Nama and Address of Facility: EVANS CHAPEL OF CHIMES 2325 YORK RD. TIMONIUM, MD. 21093

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter tha disease, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or respiretory arrest, shock, or heart failura. List only ona cause on aach line. Approximata Interval Batween Onset and Death

Immediata Causa (Final diseasa or condition resulting in death)

a. ACUTE RESPIRATORY FAILURE

Dua to (or as a consequance of):

b. CEREBRO VASCULAR ACCIDENT

Sequentially list conditions, if any, leading to immediata ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Dua to (or as a consequance of):

c. CORONARY ARTERY DISEASE

Dua to (or as a consequance of):

d. HYPERTENSION

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.

DEMENTIA, ALZHEIMERS TYPE

ORGANIC BRAIN SYNDROME

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☑ No

24b. Wara autopsy findings available prior to complation of causa of death? 1☐ Yas 2☑ No

25. Wes casa rafarred to medical examinar? 1☐ Yas 2☑ No

26. Place of Death *(Check only ona)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☑ Nursing Homa 5☐ Rasidance 8☐ Othar *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be datarmined

28a. Data of Injury *(Month, Day Year)* | 28b. Tima of Injury | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Dascribe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)* | 28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attanding Physician: The law requires that the death certificate be axecuted within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attanding physician and completely filled in by the funeral director, page 2 should be datached for use as the burial-transit

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To tha best of my knowledga, death occurred at the time, dete end place, and due to the cause(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of examinetion end/or invastigation, in my opinion, daath occurred at tha tima, data end place, and due to the ceusa(s) and manner stated.

29b. Signatura and title of certifier: Miguel Sadovnik

29c. License number: D40867

29d. Data signed *(Month, Day, Year)*: 12/11/98

30. Nama and address of person who completed cause of daath (Item 23a) (Type, Print): MIGUEL SADOVNIK. 1838 GREEN TREE Rd BALTIMORE MD 21208

State Registrar

31. Data filed *(Month, Day, Year)*: DEC 07 1998

32. Registrar's Signatura: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37400

Physician /Medical Examiner

Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

1. Decedent's Name *(First, Middle, Last)*: Ida Lockett					2. Date of Death Month: December Day: 3 Year: 1998			3. Time of Death: 1:20 AM
4a. Facility Name *(If not institution, give street and number)*: Liberty Medical Center				4b. City, Town, or Location of Death: Baltimore			4c. County of Death: NA	
5. Social Security Number: 212-40-1209	6. Sex: 1☐ M 2☒ F	7. Age *(In yrs. last birthday)*: 69 Yrs.	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth *(Month, Day, Year)*: 05-15-29		9. Birthplace *(State or Foreign Country)*: VA	
Usual Residence of Decedent								
10a. State: MD	10b. County: NA	10c. City, Town or Location: Baltimore					10d. Inside City Limits: 1☒ Yes 2☐ No	
10e. Street and Number: 2004 N. Monroe Street		10f. Zip Code: 21217			10g. Citizen of What Country?: USA			
11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th Grade; College (1-4or 5+): NA					16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Cook		16b. Kind of Business/Industry: Company	
17. Father's Name *(First, Middle, Last)*: Walker Duff					18. Mother's Name *(First, Middle, Maiden Surname)*: Francis Green			
19a. Informant's Name/Relationship *(Type, Print)*: Patricia A. Sephes					19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1631 E. Madison Street Baltimore, Maryland 21205			
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*					20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Voshell Mem. Gardens		Date: 12-09-98	20c. Location - City or Town, State: Dundalk, MD
21. Signature of Funeral Service Licensee: Deloris M Davis					22. Name and Address of Facility: Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue			

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Aspiration

Due to (or as a consequence of):
b. Hepatic Encephalopathy — Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Liver Cirrhosis — Years

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed *(Month, Day, Year)*
George E. Wicks III M.D.	D41365	December 3, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): George E. Wicks III M.D. 2600 Liberty Heights Ave. 21215

State Registrar

31. Date filed *(Month, Day, Year)*	32. Registrar's Signature
DEC 07 1998	Regina D. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37401

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Edward M. Long

2. Data of Death Month: 12 Dey: 1 Yeer: 98

3. Time of Death: 11:13 AM

4e. Facility Name (If not institution, give street and number): UMMS

4b. City, Town, or Location of Death: Baltimore, MD

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 217-54-2813

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 47 Yrs.

If Under 1 Yaar: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Yaar): FEB. 24, 1951

9. Birthplaca (State or Foraign Country): MARYLAND

Usual Rasidance of Dacedant

10a. Stata: MARYLAND

10b. County: N/A

10c. City, Town or Location: BALTIMORE CITY

10d. Insida City Limits: 1 [X] Yes 2 [ ] No

10e. Streat and Number: 807 HARLEM AVENUE

10f. Zip Coda: 21201

10g. Citizan of What Country?: USA.

11. Marital Stetus: 1 [ ] Naver Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedant Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yas, Giva Yaar or Datas:

13. Wes Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuben, Maxican, Puerto Rican, atc.) 1 [ ] Yas 2 [X] No Specify:

14. Rece - Amarican Indien, Black, Whita, atc. Specify: BLACK

15. Decedant's Education (Specify only highest grada complatad): Elementary/Secondary (0-12): 11TH GRADE; Collega (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use retired): LABORER

16b. Kind of Businass/Industry: CONSTRUCTION Co.

17. Fathar's Nama (First, Middla, Last): EDWARD H. LONG SR.

18. Mothar's Nama (First, Middle, Maidan Surnama): LUCILLE BUTLER

19a. Informant's Name/Raletionship (Type, Print): JANICE LONG (WIFE)

19b. Mailing Addrass (Straet and Number or Rural Route Number, City or Town, Stata, Zip Code): 807 HARLEM AVENUE, BALTIMORE, MD. 21201

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from Stete 4 [ ] Donation 5 [ ] Othar (Specify)

20b. Place of Disposition (Nama of cemafary, cramatory or othar placa): ARBUTUS CEMETERY

Date: 12-5-98

20c. Location - City or Town, Stata: ARBUTUS, MARYLAND

21. Signature of Funeral Service Licensee: John S. Brown JR

22. Nama and Addrass of Facility: JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTIMORE, MD. 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiretory errast, shock, or haart failure. List only one ceuse on eech line.

Approximata Intarval Between Onsat and Daath

Immediata Ceuse (Final diseasa or condition rasulting in daeth): a. Fatal Arrhythmia

Dua to (or as a consaquanca of): b. End Stage Renal Disease

Sequantially list conditions, if any, leading to immadiate ceusa. Enter Underlying Ceuse (Disease or Injury that Initiated events rasulting in daeth) Last

Due to (or as a consequance of): c.

Due to (or es e consequance of): d.

Part II. **Other aignificent conditions** contributing to death but not rasulting in tha undarlying ceusa givan in Part I.: Hypertension, Diabetes

23b. Did tobecco uae contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an eutopsy performed? 1 [ ] Yas 2 [ ] No

24b. Wara autopsy findings eveileble prior to complation of causa of death? 1 [ ] Yas 2 [ ] No

25. Was cesa refarred to medical examinar? 1 [ ] Yes 2 [ ] No

26. Placa of Daeth (Check only ona)

Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Othar: 4 [ ] Nursing Homa 5 [ ] Rasidence 6 [ ] Othar (Specify)

27. Manner of Deeth: 1 [ ] Natural 2 [ ] Accidant 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Pending investigation 6 [ ] Could not be datarmined

28a. Dete of Injury (Month, Day Year)

28b. Tima of Injury M

28c. Injury at Work? 1 [ ] Yas 2 [ ] No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, straat, factory, office building, atc. (Specify)

28f. Location (Straat and Number or Rural Route Numbar, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, daath occurred at the tima, data and place, and due to tha cause(s) and mannar statad.

29b. Signatura and titla of certifier: Walter Bellez

29c. License number: MD 46612

29d. Data signed (Month, Day, Year): 12-1-98

30. Nama and addrass of person who completed causa of daath (Item 23a) (Type, Print): Walter Bellez 22 S. Greene St. Baltimore, MD 2126

State Registrar

31. Data filad (Month, Day, Year): DEC 07 1998

32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

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Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item:27 per M.D, Items:20b,c per F.H G-766 12/7/98 reb

Certificate of Death

Reg. No. 98 37402

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Catherine ANN Lemon

2. Date of Death: Month NOV Day 27th Year 1998

3. Time of Death: 5:30 Am

4a Facility Name *(If not institution, give street and number)*: LIBERTY MEDICAL CENTER

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-58-5479

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 45 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: MARCH 03, 1953

9. Birthplace *(State or Foreign Country)*: SOUTH CAROLINA

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: N/A

10c. City, Town or Location: BALTIMORE CITY

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 3904 WOODHAVEN AVENUE

10f. Zip Code: 21216

10g. Citizen of What Country?: USA.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indien, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12TH GRADE | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: DOMESTIC WORKER

16b. Kind of Business/Industry: CLEANING SERVICE

17. Father's Name *(First, Middle, Last)*: OLLIE LEMON

18. Mother's Name *(First, Middle, Maiden Sumame)*: CATHERINE HARVIN

19a. Informant's Neme/Reletionship *(Type, Print)*: CATHERINE LEMON (MOTHER)

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 3904 WOODHAVEN AVE., BALTIMORE, MD. 2126

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Ramovel from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: ~~WOODLAWN~~ Mt. Zion Cem. CEMETERY

Date: 12-01-98

20c. Location - City or Town, Stete: ~~BALTIMORE, MARYLAND~~ Lansdowne, Md.

21. Signeture of Funerel Service Licensee: J H Brown Jr

22. Name end Address of Facility: JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 2140 N. FULTON AVE., BALTIMORE, MD. 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cerdiac or respiratory errest, shock, or heert feilure. List only one cause on each line.

Approximate Interval Batwaen Onset end Death

Immediate Cause (Finel disease or condition resulting in deeth): e. PNEUMONIA

Due to (or es e consequence of): c

Sequentially list conditions, if eny, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest

b. gram negative sepsis

Due to (or es a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Anemia

neutropenia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Deeth: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ ~~Pending~~ investigation ✓ 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred et the time, dete end plece, end due to the cause(s) end manner es steted. 2☐ **Medical Examiner:** On the besis of examinetion end/or investigetion, in my opinion, daeth occurred et the time, date end placa, end due to the cause(s) and menner steted.

29b. Signature end title of certifier: Terance Lamb MD

29c. Licansa number: D37203

29d. Date signed *(Month, Dey, Year)*: November 27 1998

30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print): Terance Lamb MD Liberty Medical Cente, Baltimore md

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 07 1998

32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend: #7 Per FH Film G766 12-14-98RC

Certificate of Death

Reg. No. 98 37403

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Edwin Leroy Lawrence, Sr.

2. Date of Death Month Day Year: December 3, 1998

3. Time of Death: 22:07

4a. Facility Name *(If not institution, give street and number)*: Carroll County General Hospital

4b. City, Town, or Location of Death: Westminster

4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 216-16-1807

6. Sex: 1☐M 2☐F — X

7. Age *(In yrs. last birthday)*: ~~74~~ 75 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Nov. 21, 1923

9. Birthplace *(State or Foreign Country)*: Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Md.

10b. County: Carroll

10c. City, Town or Location: Westminster

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 2233 E. Mayberry Rd.

10f. Zip Code: 21158

10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yas, Giva Year or Dates: WW-II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*

14. Race - American Indian, Black, Whita, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Giva kind of work done during most of working life. DO NOT use retired)*: Colonel Retired

16b. Kind of Business/Industry: Baltimore City Police

17. Father's Name *(First, Middle, Last)*: Leroy William Lawrence

18. Mother's Name *(First, Middle, Maiden Surname)*: Minnie Schwartz

19a. Informant's Name/Relationship *(Type, Print)*: Margaret E. Lawrence/wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2233 E. Mayberry Rd. Westminster, Md. 21158

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Hilltop Service Corp. | Data: 12/7/98

20c. Location - City or Town, State: Towson, Md.

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Md. 21204

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not entar tha moda of dying, such as cardiac or respiratory arrest, shock, or heart failure. List *only ona* cause *on* aach lina.

Approximate Interval Between Onset and Death

Immediata Cause (Final disaasa or condition resulting in death): a. Massive gastrointestinal bleeding — 3 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa given in Part I.: severe Coronary heart disease, Peripheal vascular disease, Congestive heart failure, Renal insff

23b. Did tobacco use contribute to the cause of death? 1☒Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yas 2☒No

24b. Ware autopsy findings available prior to completion of causa of death? 1☐Yas 2☒No

25. Was casa relarred to medical examiner? 1☐Yas 2☒No

26. Place of Death *(Check only one)*: Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA — Other: 4☐Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicida 5☐Pending investigation 6☐Could not be determined

28a. Data of Injury *(Month, Day Year)*

28b. Tima of Injury

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At homa, farm, street, factory, office building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and mannar stated.

29b. Signature and title of certifier: [signature]

29c. License number: D23015

29d. Data signed *(Month, Day, Year)*: 12/4/98

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): 217 Washington Hts. Westminster Md 21157

State Registrar

31. Data filed *(Month, Day, Year)*: DEC 07 1998

32. Registrar's Signatura: [signature] G. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attanding physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

12+1

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Catherine Marie Lanza
2. Date of Death — Month: Dec. Day: 5, Year: 1998
3. Time of Death: 8:45 P.M.
4a. Facility Name *(If not institution, give street and number)*: Continuum Care
4b. City, Town, or Location of Death: Sykesville
4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 014-05-7556
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 89 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: March 2, 1909
9. Birthplace *(State or Foreign Country)*: New Hampshire

Usual Residence of Decedent

10a. State: Maryland
10b. County: Carroll
10c. City, Town or Location: Sykesville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7309 2nd Ave.
10f. Zip Code: 21784
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indien, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 9th grade — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Secretary
16b. Kind of Business/Industry: office work

17. Father's Name *(First, Middle, Last)*: Pasquale Furnelli
18. Mother's Name *(First, Middle, Maiden Surname)*: Theresa Baldasaro

19a. Informant's Name/Relationship *(Type, Print)*: Kathleen T. Bibeau daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 290 Carnies Lane Sykesville, MD 21784

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Carroll Cremation, Inc.
Date: Dec. 7
20c. Location - City or Town, State: Hampstead, Maryland

21. Signature of Funeral Service Licensee: James B Cowley
22. Name and Address of Facility: Burrier-Queen Funeral Directors, P.A. 1212 W. Old Liberty Road Winfield, MD 21784

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Atherosclerotic Coronary Vascular Disease — 10yr

Due to (or as a consequence of):
b.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Robert L. Moss
29c. License number: 032082
29d. Date signed *(Month, Day, Year)*: 12/7/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Robert L. Moss 114 Business Center Drive Reisterstown, Md. 21136

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 07 1998
32. Registrar's Signature: Jennie G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37405

Physician /Medical Examiner

1. Decedent's Nema *(First, Middle, Last)*: Leonard Charles Lannak

2. Data of Deeth — Month: NOVEMBER Dey: 28 Yeer: 1998

3. Time of Death: 2340

4e. Facility Name *(If not institution, giva street end number)*: ST. AGNES HEALTHCARE

4b. City, Town, or Location of Daath: BALTIMORE

4c. County of Death:

Funeral Director

5. Social Security Number: 170-09-4944

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 81 Yrs.

If Under 1 Year — Months: Days: If Under 24 Hrs. — Hours: Min.:

8. Dete of Birth *(Month, Dey, Yeer)*: July 10, 1917

9. Birthpleca *(Stata or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. Stata: Maryland

10b. County: Baltimore

10c. City, Town or Location: Randallstown

10d. Inside City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 3603 Blair Avenue

10f. Zip Code: 21133

10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1☐ Never Merriad 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Yeer or Detes: WWII

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yas 2☒ No *Specify:*

14. Race - American Indien, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 College (1-4or 5+): 2

16e. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Transportation Officer

16b. Kind of Business/Industry: United States Army

17. Fether's Neme *(First, Middle, Last)*: Bernard John Lannak

18. Mother's Neme *(First, Middle, Maiden Sumama)*: Jane Amelia Healey

19a. Informant's Neme/Reletionship *(Type, Print)*: Helen Lannak (wife)

19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 3603 Blair Avenue, Randallstown, Maryland 21133

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cametery, cremetory or othar piece)*: Maryland State Veterans

Date: DEC. 4

20c. Locetion - City or Town, State: Garrison Forest, Maryland

21. Signature of Funeral Service Licensee: John S. Falk (#00804)

22. Neme end Address of Facility: Loring Byers Funeral Directors, Inc. 8728 Liberty Rd. Randallstown, Maryland 21133

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications thet caused tha death. Do not enter tha moda of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset end Deeth
Immediete Ceuse (Finel diseese or condition rasulting in death)	e. Multiple organ failure	10 days
	Due to (or es e consequenca of):	
Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceusa (Disease or injury thet initieted events resulting in death) Lest	b. Sepsis	12 days
	Due to (or as a consequence of):	
	c. Pancreatic cancer	2 months.
	Due to (or as a consequenca of):	
	d.	

Part II. **Other atgnificant conditiona** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uaa contribute to the cauee of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☑ No

24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical exeminer? 1☐ Yes 2☑ No

26. Piece of Deeth *(Check only one)*: Hospital: 1☑ Inpatiant 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Rasidance 6☐ Other *(Specify)*

27. Mennar of Deeth: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, streat, factory, offica building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Routa Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner es steted. 2☐ **Medtcal Examiner:** On the basis of exemination end/or investigetion, in my opinion, deeth occurred et the time, date end place, and due to the ceuse(s) end manner steted.

29b. Signeture end title of certifier: M. Bayar M.D.

29c. License number: D 09152

29d. Date signed *(Month, Dey, Yeer)*: November 28, 1998

30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print): A. AKBAROV M.D. / 900 Caton Ave, Baltimore, MD 21229

State Registrar

31. Dete filed *(Month, Day, Yeer)*: DEC 07 1998

32. Registrar's Signature: Penina G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

NAME: LANNAK, LEONARD C.
Division of Vital Records, P.O. Box 68760,

15x1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37406

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ethel May Lyell

2. Date of Death: Month Dec, Day 01, Year 1998

3. Time of Death: 10:15am

4a. Facility Name (If not institution, give street and number): Manor Care of Sliver Spring

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 214-22-2874

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 94 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.

8. Date of Birth (Month, Day, Year): May 14, 1904

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Randallstown

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3801 Schnaper Drive

10f. Zip Code: 21133

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12th Grade; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Nurse

16b. Kind of Business/Industry: Kernans Hospital

17. Father's Name (First, Middle, Last): William H. Pothast

18. Mother's Name (First, Middle, Maiden Surname): Agnes Bryant

19a. Informant's Name/Reletionship (Type, Print): Joyce Tankersley - Niece

19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code): 6033 Snow Crystal; Columbia, Maryland 21044

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Mt. Olive Cemetery Dete: 12/6/98

20c. Location - City or Town, State: Randallstown, Maryland

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name end Address of Facility: Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, Maryland 21133

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Death

Immediate Cause (Finel diseese or condition resulting in deeth): a. Congestive heart failure — 1 year

Due to (or as e consequence of):

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Diseese or injury thet initiated events resulting in deeth) Lest:

b. Dementia

Due to (or as e consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other eignificent conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the ceuse of deeth? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? 1☐ Yes 2☒ No

25. Was case referred to medical exeminer? 1☐ Yes 2☒ No

26. Plece of Death (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Deeth: 1☒ Naturat 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physicien:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner es steted. 2☐ **Medical Exeminer:** On the basis of examination end/or Investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) end manner stated.

29b. Signature and title of certifier: ▶ [signature]

29c. License number: D 43237

29d. Date signed (Month, Day, Yeer): 12-3-98

30. Neme end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print): Paul Armstrong, M.D. 14201 Laurel Park Dr. Ste 102 Laurel MD 20707

State Registrar

31. Dete filed (Month, Dey, Year): DEC 07 1998

32. Registrer's Signature: ▶ [signature] G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Meryland Department of Health end Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial permit

DHMH 16 Rev 6/95

98-6977-510
crn
Cheryl Lyde

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37407

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Cheryl L. Lyde
2. Date of Death (Month, Day, Year): December 01, 1998
3. Time of Death: 5:47 P.M.
4a. Facility Name (If not institution, give street and number): 777 Washington Boulevard
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-92-9506
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 28 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 12 07 69
9. Birthplace (State or Foreign Country): M.D.

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 777 Washington Blvd
10f. Zip Code: 21230
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11th grade — College (1-4 or 5+): na
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Nurse Assistant
16b. Kind of Business/Industry: UNKNOWN

17. Father's Name (First, Middle, Last): Willouis Lyde Jr.
18. Mother's Name (First, Middle, Maiden Surname): Vermel McGee

19a. Informant's Name/Relationship (Type, Print): Willouis Lyde Jr. -Father
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8601 Pollyhill Ct, Baltimore Md 21244

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or other place): King Memorial Park
Date: 12/7/98
20c. Location - City or Town, State: Randallstown, Md

21. Signature of Funeral Service Licensee: ▶ Gabrielle Cook
22. Name and Address of Facility: March F/H West 4300 Wabash Ave, Baltimore Md 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Strangulation and Sharp Force
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Injuries
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☑ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☑ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☒ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year): 12/1/98 Found
28b. Time of Injury: 1654 M
28c. Injury at Work? 1☐ Yes 2☑ No
28d. Describe how injury occurred: Assaulted
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Home; 777 Washington Blvd; Balto, Md.
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ J. Pestaner, M.D
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): December 02, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): DEC 07 1998
32. Registrar's Signature: Debra B. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

6

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ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37408

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Richard T. Leach
2. Data of Death: Month Dec Day 1 Year 1998
3. Time of Death: 1027
4a. Facility Name (If not institution, give street and number): University of Maryland Medical System
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: None

Funeral Director

5. Social Security Number: 213-30-0431
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 66 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): JUNE 30, 1932
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ANNE ARUNDEL
10c. City, Town or Location: LINTHICUM HEIGHTS
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 527 HAWTHORNE ROAD
10f. Zip Code: 21090
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? [X] Yes 2 [ ] No. If Yes, Give Year or Dates: 1952-1954
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4 or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): FIELD REPRESENTATIVE/SALES
16b. Kind of Business/Industry: INSURANCE

17. Father's Name (First, Middle, Last): RICHARD H. LEACH
18. Mother's Name (First, Middle, Maiden Surname): HILDA BARBARA FRANK

19a. Informant's Name/Relationship (Type, Print): EDITH H. LEACH (WIFE)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 527 HAWTHORNE ROAD, LINTHICUM HEIGHTS, MD. 21090

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MEADOWRIDGE MEMORIAL PARK
Date: 12/4/98
20c. Location - City or Town, State: ELKRIDGE, MD.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Biventricular failure	10 hours
Due to (or as a consequence of): b.	Coronary artery disease	Years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	Myocardial infarction	4 days
Due to (or as a consequence of): d.	Ventricular septal defect (Post-infarct)	10

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: PO 6030
29d. Date signed (Month, Day, Year): Dec 1 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): KENNETH SAUM, M.D. VMMS 22 S. Greene St Baltimore MD 21201, Division of CT Surgery

State Registrar

31. Date filed (Month, Day, Year): DEC 07 1998
32. Registrar's Signature: [signature] G. Sparks

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37409

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): PAUL C. MERENDA
2. Data of Death — Month: DEC Day: 6 Year: 1998
3. Time of Death: 2 AM
4a. Facility Name (If not institution, give street and number): 7 PERCH CT.
4b. City, Town, or Location of Death: CHASE
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 219-32-4406
6. Sex: 1 ☑ M 2 ☐ F
7. Age (In yrs. last birthday): 62 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): JAN. 12, 1936
9. Birthplace (State or Foreign Country): MD.

Usual Rasidance of Decedent

10a. Stata: MD
10b. County: BALTIMORE
10c. City, Town or Location: CHASE
10d. Inside City Limits: 1 ☐ Yas 2 ☑ No
10e. Street and Number: 7 PERCH CT.
10f. Zip Code: 21220
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Nevar Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced
12. Was Decedent Evar in U.S. Armed Forcas? 1 ☐ Yes 2 ☑ No If Yas, Giva Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:
14. Race - American Indian, Black, Whita, etc. Specify: WHITE

15. Decedant's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — Collega (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): PLUMBER
16b. Kind of Business/Industry: PLUMBING

17. Father's Nama (First, Middle, Last): PAUL MERENDA
18. Mother's Nama (First, Middle, Maiden Surname): AMELIA MAZZARELLO

19a. Informant's Name/Reletionship (Type, Print): JENNIFER MERENDA, D-I-L
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7 PERCH CT. BALTIMORE, MD 21220

20a. Mathod of Disposition: 1 ☐ Burial 2 ☑ Cremation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): EVANS FUNERAL CHAPEL BEL AIR - MD. — Date: DEC. 10 1998
20c. Location - City or Town, Stata: FOREST HILL, MD

21. Signature of Funeral Service Licansee: Trisha S. Wells
22. Nama and Address of Facility: EVANS CHAPEL OF MEMORIES 5800 HARFORD RD BALTIMORE, MD. 21234

Physician /Medical Examiner

23a. Part I. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failura. List only ona causa on aach lina.

Approximata Interval Between Onset and Death

Immediata Causa (Final disaasa or condition rasulting in death)
a. Small cell lung cancer — 8months
Dua to (or as e consequence of):

Sequentially list conditions, if eny, laading to immadiate causa. Entar Undarlying Cause (Diseasa or injury that initiated evants rasulting in daath) Last
b. Dua to (or as a consequence of):
c. Dua to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in tha underlying cause given in Part I.
Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings aveilable prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was casa rafarred to medical examinar? 1 ☐ Yas 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accidant 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Panding invastigation 6 ☐ Could not be determined

28a. Data of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28a. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifiar (Check only one): 1 ☒ Certifying Physician: To tha best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On tha basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29b. Signatura and titla of certifier: Julie R Brahmer, MD
29c. License number: D0051770
29d. Data signed (Month, Day, Year): December 7 1998

30. Name and eddress of person who completed causa of death (Item 23a) (Type, Print): Julie R. Brahmer, MD Johns Hopkins Hospital Baltimore, MD 21287

State Registrar

31. Data filed (Month, Day, Year): DEC 07 1998
32. Registrar's Signatura: Linda G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic avant, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the Attending Physician and completely filled in by the funeral director, page 2 should be detached for use at the burial-transit

15

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37410

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: JOSEPH THOMPSON MAURER

2. Date of Death (Month, Day, Year): DECEMBER 3, 1998

3. Time of Death: 10:05 AM

4a. Facility Name *(If not institution, give street and number)*: Saint Joseph Medical Center

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 220-36-0295

6. Sex: 1 ☑ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 58 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: APRIL 21, 1940

9. Birthplace *(State or Foreign Country)*: MD.

Usual Residence of Decedent

10a. State: MD

10b. County: BALTIMORE

10c. City, Town or Location: PARKVILLE

10d. Inside City Limits: 1 ☐ Yes 2 ☑ No

10e. Street and Number: 8510 OAKLEIGH RD

10f. Zip Code: 21234

10g. Citizen of What Country?: U.S.A.

11. Meritel Stetus: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No *Specify:*

14. Raca - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: SUPERVISOR

16b. Kind of Business/Industry: COUNTY UTILITIES

17. Father's Name *(First, Middle, Last)*: JOSEPH T. MAURER

18. Mother's Name *(First, Middle, Maiden Surname)*: KATHERINE A. SEVERN

19a. Informant's Name/Relationship *(Type, Print)*: ROSALIE MAURER, SPOUSE

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8510 OAKLEIGH RD. BALTIMORE, MD. 21234

20a. Method of Disposition: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: MORELAND MEMORIAL PARK

Dete: DEC. 5, 1998

20c. Location - City or Town, State: PARKVILLE, MD.

21. Signeture of Funeral Service Licensee: Keith S. Weller

22. Name end Address of Facility: EVANS CHAPEL OF MEMORIES 8500 HARFORD RD. BALTIMORE, MD. 21234

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final diseese or condition resulting in death)

a. CARDIAC FAILURE — 6 WEEKS

Due to (or es a consequenca of):

b. PNEUMONIA — 3 DAYS

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequenca of):

c. VENTILATORY FAILURE — 6 WEEKS

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uss contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*: Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residenca 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, offica building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: Linda S. Barr MD

29c. License number: D 35453

29d. Date signed *(Month, Day, Year)*: 12/3/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): LINDA BARR, M.D., 120 STR. PIERRE DR., TOWSON, MARYLAND 21204

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 07 1998

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Meryland Department of Health and Mantel Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use at the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item#29c per FR G766 12/29/98 EW

Certificate of Death

Reg. No. 98 37411

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Victor Albert Mikusauskas

2. Date of Death Month: DECEMBER Dey: 2 Yeer: 1998

3. Time of Death: 7:30 P.M.

4a. Facility Name (If not institution, give street and number): Union Memorial Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-14-2194

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 75 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Dey, Yeer): 01-08-1923

9. Birthplece (Stete or Foreign Country): Maryland

Usuel Residence of Decedent

10a. Stete: Maryland

10b. County: N/A

10c. City, Town or Locafion: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 2610 N. Calvert Street

10f. Zip Code: 21218

10g. Citizen of What Country?: U.S.A.

11. Meritel Stafus: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U,S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:

14. Race - American indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed): Elementary/Secondary (0-12): 9 Years | Collega (1-4or 5+): N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Carpenter

16b. Kind of Business/Industry: Self Employed

17. Fether's Name (First, Middle, Last): Anthony Mikusauskas

18. Mother's Name (First, Middle, Maiden Sumeme): Adell Gelgota

19a. Informant's Neme/Ralationship (Type, Print): Paul Mikusauskas (Brother)

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 3516 Old York Road Baltimore, Maryland 21218

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Hilltop Services Corp. Date: 12-7-98

20c. Location - City or Town, Stata: Towson, Maryland

21. Signature of Funeral Service Licensee: J. Wayne Osterling

22. Name end Address of Facility: Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214

Physician /Medical Examiner

23a. Part I. Enter the disease, or complicafions that ceused the deafh. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Deafh

Immedia'e Cause (Final disease or condition resulting in death): a. DISSECTING THORACIC ANEURYSM — 1 DAY

Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated avants resulting in deeth) Last:

b.

Due to (or es e consequence of):

c.

Due fo (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but nof resulting in the underlying ceuse given in Pert I.: ESRD, CAD S/P CABG, HTN, ANEMIA

23b. Did tobecco use contribute to the csuae of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was en eutopsy performed? 1 [✓] Yes 2 [ ] No

24b. Were autopsy findings availeble prior fo completion of ceuse of daeth? 1 [ ] Yes 2 [✓] No

25. Was casa referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Plece of Death (Check only one): Hospital: 1 [✓] Inpafient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Othar (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicida 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Yeer)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Spacify)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician**: To the bast of my knowledge, death occurred at tha tima, data and place, and due to the ceusa(s) end mannar es stated. 2 [ ] **Medical Examiner**: On tha basis of examination end/or investigation, in my opinion, daath occurred at tha tima, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and tifla of certifier: Anuradha Aeun, M.D

29c. Licansa number: ~~AT 2438946~~ P 11840

29d. Date signed (Month, Dey, Yeer): December - 2 - 1998

30. Name end address of person who complated cause of death (Item 23e) (Type, Print): UNION MEMORIAL HOSPITAL, BALTMORE, MD - 21218

State Registrar

31. Date filed (Month, Day, Yeer): DEC 07 1998

32. Registrer's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

VICTOR, MIKUSAUSKAS

471

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 98 37412

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOHN MERCER
2. Date of Death: Month 11 Day 29 Year 98
3. Time of Death: 10:13 PM
4a. Facility Name (If not institution, give street and number): BON SECOURS HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 245-42-2206
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 68 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MAY 07, 1930
9. Birthplace (State or Foreign Country): NORTH CAROLINA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE CITY
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 2316 ARUNAH AVENUE
10f. Zip Code: 21216
10g. Citizen of What Country?: USA.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 04-04-51 / 01-03-53
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12TH GRADE; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): MANAGER
16b. Kind of Business/Industry: FOOD INDUSTRY

17. Father's Name (First, Middle, Last): UNKNOWN
18. Mother's Name (First, Middle, Maiden Surname): UNKNOWN

19a. Informant's Name/Relationship (Type, Print): VINCENT MERCER (SON)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3329 WINTERBOURNE RD, BALTIMORE, MD. 21216

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): CROWNSVILLE CEMETERY
Date: 12-03-98
20c. Location - City or Town, State: CROWNSVILLE, MD.

21. Signature of Funeral Service Licensee: John F. Williams
22. Name and Address of Facility: JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTIMORE, MD. 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. SEPSIS

Due to (or as a consequence of):
b. HYPERTENSIVE ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE

Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. CARDIOMYOPATHY

Due to (or as a consequence of):
d. CONGESTIVE HEART FAILURE

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Rosita R. Cruz
29c. License number: D0030355
29d. Date signed (Month, Day, Year): 11/29/98

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): ROSITA R. CRUZ M.D. BON SECOURS HOSPITAL

State Registrar

31. Date filed (Month, Day, Year): DEC 07 1998
32. Registrar's Signature: Jerome G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37413

NAME KNOWN TO PHYSICIAN: Martin, Roland
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Physician /Medical Examiner | **Funeral Director** | **To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last): Roland Martin
2. Date of Death (Month, Day, Year): December 3 1998
3. Time of Death: 6:00PM
4a. Facility Name (If not institution, give street and number): VA Maryland Health Care System
4b. City, Town, or Location of Death: Perry Point
4c. County of Death: Cecil
5. Social Security Number: 215-09-9672
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Mar 2, 1912
9. Birthplace (State or Foraign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Insida City Limits: 1 [X] Yas 2 [ ] No
10e. Street and Number: 2909 Keswick Road
10f. Zip Code: 21211
10g. Citizen of What Country?: U.S.A
11. Marital Status: 1 [ ] Nevar Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forcas? 1 [X] Yas 2 [ ] No If Yas, Giva Yaar or Datas: WW II
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.): 1 [ ] Yas 2 [X] No Specify:
14. Race - American Indian, Black, White, atc. Specify: White
15. Decedent's Education (Specify only highast grade completed): Elementary/Secondary (0-12): 7 | College (1-4or 5+):
18a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired): Butcher
16b. Kind of Businass/Industry: Cochran and Hill Co.
17. Fathar's Nama (First, Middla, Last): McClellan Martin
18. Mother's Nama (First, Middla, Maiden Surname): Ella Canapp
19a. Informant's Name/Ralationship (Type, Print): Oda Martin (Daughter)
19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda): 2909 Keswick Road, Baltimore, Maryland 21211
20a. Mathod of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Removal from Stata 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Nama of cematary, cramatory or other place): Pine Grove UMC Cemetery
Data: 12/12/98
20c. Location - City or Town, Stata: Rayville, Maryland
21. Signature of Funaral Sarvice Licensee: A. Alan Seitz, Jr.
22. Nama and Addrass of Facility: A. Alan Seitz, Jr. Funeral Home 3818 Roland Avenue, Baltimore, Maryland 21211

Physician /Medical Examiner | **Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

23a. Part1. Entar tha disease, or complications that caused tha death. Do not entar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona cause on aach lina.

Approximata Intarval Between Onsat and Death

Immediate Causa (Final diseasa or condition rasulting in deeth):
a. Respiratory infection — Unknown
Dua to (or as a consequence of):
b.
Dua to (or as a consequence of):
c.
Dua to (or as a consequance of):
d.

Sequentially tist conditions, if any, laading to immadiata cause. Entar Underlying Ceuse (Disease or Injury that initiated events rasulting in deeth) Last

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was en autopsy performed? 1 [ ] Yas 2 [X] No
24b. Wara autopsy findings available prior to completion of causa of deeth? 1 [ ] Yas 2 [ ] No

25. Was case referred to medicat examinar? 1 [ ] Yas 2 [X] No
26. Place of Deeth (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Homa 5 [ ] Residence 6 [ ] Othar (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicida 5 [ ] Pending invastigetion 6 [ ] Could not be determined
28a. Data of Injury (Month, Day Yaar)
28b. Tima of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifiar (Check only one): 1 [X] **Certifying Physician:** To tha best of my knowledge, daath occurred at tha tima, data and place, and dua to the cause(s) and mennar as stated. 2 [ ] **Medical Examiner:** On the basis of axamination and/or invastigation, in my opinion, daath occurred at tha time, date end place, and due to tha causa(s) and manner stated.

29b. Signature and titla of certifier: Kenneth Robertson
29c. Licansa number: D40602
29d. Data signed (Month, Day, Year): 12/3/98

30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print): Kenneth Mills-Robertson, M.D. VA Maryland Health Care System Perry Point, MD

State Registrar

31. Data filed (Month, Day, Year): DEC 07 1998
32. Registrar's Signature: Lenora G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED #23A,23b,24a,25,26,27,29A per G766 PHY 12/7/98EW **Certificate of Death**

Reg. No. 98 37414

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year	3. Time of Death
MARY	MACFARLANE	November 8,1998	12:56 am

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Memorial Hospital	Cumberland	Allegany

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	If Under 1 Year Days	If Under 24 Hrs. Hours	If Under 24 Hrs. Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-18-4315	1☐ M 2☒ F	90 Yrs.					June 1, 1908	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Allegany	Cumberland	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
Furnace Street Extended	21502	U.S.A.

11. Marital Status	12. Was Decedent Evar in U.S. Armed Forcas?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, atc.)	14. Race - American Indian, Black, White, atc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Giva Yaar or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondery (0-12)	College (1-4or 5+)		
12	0	Owner	Ice Cream

17. Fathar's Nama (First, Middle, Last)	18. Mother's Name (First, Middla, Maiden Surname)
Charles E. Dawson	Emma Elizabeth Spiker

19a. Informant's Name/Relationship (Typa, Print)	19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code)
Joseph William Woods/son	45 North West Avenue, Inverness, Florida 34452

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other place)	Date	20c. Location - City or Town, Stata
1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other (Specify)			

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Joseph B. Van Sant Boyd B. Van Sant	State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused tha daath. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only ona cause on each line.

		Approximate Interval Between Onsat and Daath
Immediate Cause (Final disease or condition resulting in death)	e. Acute Renal Failure	Ten Days
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Last	b. DIABETES MELLITUS	YEARS
Due to (or as a consequance of):		
	c.	
Due to (or as a consequance of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performad?	24b. Were eutopsy findings available prior to complation of causa of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Piece of Injury - At home, farm, street, factory, offica building, etc. (Specify)			28f. Location (Street and Number or Rural Routa Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner es stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and menner stated.

29b. Signature and title of certifiar	29c. License number	29d. Date signed (Month, Day, Year)
Faran MD	D 33280	November 8, 1998

30. Nama and address of person who completed cause of death (Item 23e) (Type, Print)

Dr. Sunil Gupta-Johnson Heights Medical Building-Cumberland, MD 21502

State Registrar

31. Data filed (Month, Day, Year)	32. Registrar's Signatura
DEC 07 1998	Geneva B. Sparks

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funerel director, page 2 should be detechad for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

AOP
23A
23b
24A
25
26
27
29A

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37415

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ruth Virginia Moon

2. Date of Death: Month DECEMBER Day 2, Year 1998

3. Time of Death: 5:45 AM.

4a. Facility Name (If not institution, give street and number): Burke Grove Nursing Home

4b. City, Town, or Location of Death: Sandy Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 216-10-2918

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.

8. Date of Birth (Month, Day, Year): 10/11/1917

9. Birthplace (State or Foreign Country): Indiana

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: Montgomery

10c. City, Town or Location: Derwood

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 7609 Warbler Lane

10f. Zip Code: 20855

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Chester Starr Rader

18. Mother's Name (First, Middle, Maiden Surname): Amy Lee Rodenhiser

19a. Informant's Name/Relationship (Type, Print): Virginia L. Azadi

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7609 Warbler Lane Derwood, Maryland 20855

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Woodlawn, Cemetery

Date: 12/5/98

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Juanita R Thomas

22. Name and Address of Facility: John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. METASTATIC COLON CARCINOMA — YEARS.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Ted Howe

29c. License number: D33700

29d. Date signed (Month, Day, Year): DECEMBER 2, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): TED HOWE 7542 OVERLOOK DRIVE, BOONSBORO, MD 21713

State Registrar

31. Date filed (Month, Day, Year): DEC 07 1998

32. Registrar's Signature: Geneva G. Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37416

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CHARLES SLYVESTER NICHOLSON, JR.
2. Date of Death (Month, Day, Year): December 3, 1998
3. Time of Death: 3:45 PM
4a. Facility Name (If not institution, give street and number): Millenium Nursing Home
4b. City, Town, or Location of Death: Glen Burnie
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 215-03-3345
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 17, 1915
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Riviera Beach
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 8578 Main Avenue
10f. Zip Code: 21122
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 8 yr's; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Supervisor
16b. Kind of Business/Industry: Crown, Cork & Seal

17. Father's Name (First, Middle, Last): Charles S. Nicholson
18. Mother's Name (First, Middle, Maiden Surname): Nellie Hammer

19a. Informent's Neme/Relationship (Type, Print): Margaret C. Nicholson - Wife
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 8578 Main Avenue Riviera Beach, MD 21122

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Neme of cemetery, crematory or other place): Loudon Park
Date: 12/7/98
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: ▶ Paul L. Hartsock, Jr.
22. Name and Address of Facility: Baltimore, MD 21214 Leonard J. Ruck, Inc. 5305 Harford Rd.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. probable cardiac arrhythymia — couple minutes
Due to (or as a consequence of):
b. end stage congestive heart failure — couple months
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last
c. atherosclerotic coronary artery disease — 10 years
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cauee of death? 1 [ ] Yes 2 [✓] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No
24b. Were autopsy findings eveilable prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [✓] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Sulcide 4 [ ] Homlcide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as steted. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Jerry D. Sharbek, M.D.
29c. License number: D29767
29d. Date signed (Month, Day, Year): 12-03-1998

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Jerry D. Sharbek, M.D. 8418 Baltimore-Annapolis Blvd Pasadena MD 21122

State Registrar

31. Date filed (Month, Day, Year): DEC 07 1998
32. Registrar's Signature: ▶ Bernard G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

10

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37417

Physician /Medical Examiner

1. Decedant's Nama *(First, Middla, Last)*: Milton B. Ostrowski
2. Dete of Death Month Day Yaar: DECEMBER, 3, 1998
3. Tima of Death: 8:45 PM
4a. Facility Neme *(If not institution, giva street and number)*: North Arundel Hospital
4b. City, Town, or Location of Death: Glen Burnie
4c. County of Death: AA

Funeral Director

5. Social Security Number: 215-03-7241
6. Sex: 1☑ M 2☐ F
7. Aga *(In yrs. last birthday)*: 79 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Deta of Birth *(Month, Day, Yaar)*: March 28, 1919
9. Birthplaca *(Stata or Foreign Country)*: Maryland

Usual Rasidanca of Dacadant

10a. Steta: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Severna Park
10d. Insida City Limits: 1☐ Yas 2☑ No
10e. Street end Number: 384 North Drive
10f. Zip Coda: 21146
10g. Citizan of Whet Country?: USA

11. Marital Status: 1☑ Navar Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedant Evar in U.S. Armed Forcas? 1☑ Yas 2☐ No If Yas, Giva Year or Datas: WW II
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 1☐ Yas 2☑ No *Specify:*
14. Raca - American Indian, Black, Whita, atc. *Specify:* White

15. Decedant's Education *(Specify only highest grada complatad)*: Elementary/Secondary (0-12): 8th; College (1-4or 5+):
16a. Decedant's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa retired)*: Longshoreman
16b. Kind of Business/Industry: Shipping

17. Fether's Nama *(First, Middla, Last)*: Frank Ostrowski
18. Mothar's Nama *(First, Middla, Maidan Surnama)*: Magdalena Walega

19a. Informant's Name/Ralationship *(Type, Print)*: Bertha Sobus / Sister
19b. Mailing Address *(Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 384 North Drive, Severna Park, Maryland 21146

20a. Mathad of Disposition: 1☑ Burial 2☐ Cramation 3☐ Ramoval from State 4☐ Donation 5☐ Othar *(Spacify)*
20b. Placa of Disposition *(Name of cematary, cramatory or other place)*: Holy Rosary Cemetery
Data: 12/7/98
20c. Location - City or Town, Steta: Baltimore, Maryland

21. Signature of Funeral Service Licensee: David J. Weber
22. Nama and Address of Facility: David J. Weber Funeral Homes, P.A. 401 S. Chester Street Baltimore, Maryland 21231

Physician /Medical Examiner

23a. Part1. Entar the disease, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or respiretory arrast, shock, or haart failura. List only ona causa on aach line.

Approximata Interval Between Onsat and Death

Immediata Causa (Final disaasa or condition resulting in death)
a. SEPTICEMIA — 1 DAY

Dua to (or as a consaquanca of):
b. ACUTE MYELOGENOUS LEKEMIA

Sequantially list conditions, if any, laading to immadiata cause. Entar Underlying Causa (Disaase or injury that initiated avants rasulting in daath) Last
Dua to (or es e consequanca of):
c.
Due to (or es e consequence of):
d.

Part II. **Other aignificant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.

23b. Did tobacco use contribute to the cauae of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☑ No
24b. Were autopsy findings available prior to complation of causa of death? 1☐ Yes 2☐ No

25. Was casa rafarrad to medical examinar? 1☐ Yas 2☑ No

26. Placa of Death *(Check only one)*: Hospital: 1☑ Inpatiant 2☐ ER/Outpatiant 3☐ DOA; Othar: 4☐ Nursing Homa 5☐ Rasidanca 6☐ Othar *(Specify)*

27. Manner of Death: 1☐ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding investigation 6☐ Could not be datarmined

28a. Placa of Injury - At home, farm, street, factory, offica building, atc. *(Specify)*
28b. Tima of Injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurred
28e. Date of Injury *(Month, Day Year)*
28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred at tha tima, data and place, and dua to the causa(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, daath occurred at the tima, data and place, and due to the cause(s) and mannar statad.

29b. Signature and title of certifier: MD
29c. Licansa number: D51245
29d. Date signed *(Month, Day, Yaar)*: December 3, 1998

30. Nama and address of person who complatad causa of daath (Item 23e) (Type, Print): SAJID SHARIF NORTH ARUNDEL HOSPITAL - MD

State Registrar

31. Date filed *(Month, Day, Yaar)*: DEC 07 1998
32. Registrar's Signatura: Jenna G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that this certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

10+1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37418

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Raymond Pritchard

2. Date of Death: Month DECEMBER Day 5 Year 1998

3. Time of Death: 3:35 PM

4a. Facility Name (If not institution, give street and number): FRANKLIN SQUARE HOSPITAL CENTER

4b. City, Town, or Location of Death: ROSEDALE

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 235-28-9447

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 74 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): April 19, 1924

9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10e. State: Md.

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 8051 Bank Street

10f. Zip Code: 21224

10g. Citizen of What Country? USA

11. Maritel Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Brewer

16b. Kind of Business/Industry: Warehouse

17. Father's Name (First, Middle, Last): Dow Pitchard

18. Mother's Name (First, Middle, Maiden Sumame): Dovie Street

19a. Informant's Name/Relationship (Type, Print): Ruth Pitchard / wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8051 Bank Street Baltimore Md. 21224

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Parkwood Cemetery Date: 12/9/98

20c. Location - City or Town, State: Baltimore Md.

21. Signature of Funeral Service Licensee: R. Terry Connelly

22. Name and Address of Facility: Connelly Funeral Home of Essex 300 Mace AVe. Baltimore Md. 21221

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. BRONCHOGENIC CARCINOMA	1 YEAR
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as e consequence of):	
	d.	

Part II. **Other signifIcent conditIons** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uee contribute to the ceuse of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was en autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings availeble prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was cese referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Phyeicfen:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture end title of certifier: M. [illegible]

29c. License number: D45475

29d. Date signed (Month, Dey, Year): 12-5-98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MOHAMMAD RAHMANA MD. 9000 FRANKLIN SQ. DR. BALTO, MD 21237

State Registrar

31. Date filed (Month, Day, Year): DEC 07 1998

32. Registrar's Signature: Steven B. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

P2 ITCHARD, RAYMND

6

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37419

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Woodrow Rutherford Jr.

2. Date of Death: Month November Day 27 Year 1998

3. Time of Death: 3:34pm

4a. Facility Name (If not institution, give street and number): Sinai Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

Funeral Director

5. Social Security Number: 220 54 5968

6. Sex: 1☑M 2☐F

7. Age (In yrs. last birthday): 47 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 9 1951

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Lutherville

10d. Inside City Limits: 1☐Yes 2☑No

10e. Street and Number: 11501 Greenspring Ave.

10f. Zip Code: 21093

10g. Citizen of What Country? USA

11. Meritel Status: 1☐Never Married 2☑Married 3☐Widowed 4☐Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☑Yes 2☐No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐Yes 2☑No Specify:

14. Race - Americen Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Accountant

16b. Kind of Business/Industry: Financial

17. Fether's Name (First, Middle, Last): Woodrow Rutherford Sr.

18. Mother's Name (First, Middle, Malden Surneme): Lena Holdway

19a. Informant's Name/Relationship (Type, Print): Gale Rutherford

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11501 Greenspring Ave Lutherville MD. 21093

20a. Method of Disposition: 1☑Burial 2☐Cremation 3☐Removal from State 4☐Donetion 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other piece): Garrison Forest Vet. Cemetery

Date: December 3, 1998

20c. Location - City or Town, Stete: Garrison, Maryland

21. Signature of Funeral Service Licensea: ▶ [signature]

22. Name end Address of Facility: Evans Funeral Chapel 8800 Harford Rd. Baltimore MD. 21234

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or haart failure. List only ona cause on each line.

Approximete Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CARDIAC ARRHYTHMIA

Due to (or as a consequence of):

b. Acute MI — 6 days

Sequentially list conditions, if eny, leeding to immediete ceuse. Enter Underlying Cause (Disease or Injury thet initieted events resulting in death) Last

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown

24a. Was an autopsy performed? 1☑Yes 2☐No

24b. Were autopsy findings availeble prior to completion of ceuse of death? 1☐Yes 2☐No

25. Was cese referred to medical examiner? 1☐Yes 2☑No

26. Place of Death (Check only one): Hospital: 1☐inpatient 2☑ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☑Natural 2☐Accident 3☐Sulcide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Dascribe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the ceusa(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at tha time, date and place, and due to tha ceuse(s) and manner stated.

29b. Signature and title of certifier: ▶ Mark G Midei

29c. License number: D30042

29d. Date signed (Month, Day, Year): 4/30/98

30. Name and address of person who completed ceusa of death (Item 23a) (Type, Print): Mark Midei M.D. St. Joseph Medical Center 7620 York Rd. Towson MD. 21204

State Registrar

31. Date filed (Month, Day, Year): DEC 07 1998

32. Registrar's Signeture: [signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Meryland Department of Health end Mental Hygiene. **Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

10

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 90 37420

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GEORGE SOLOMON RICKS
2. Dete of Deeth: Month NOV. Dey 28, Yeer 1998
3. Time of Death: 7 32 PM
4a. Fecility Neme (If not institution, give street end number): UNION MEMORIAL HOSPITAL
4b. City, Town, or Location of Deeth: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Sociel Security Number: 214-30-6737
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. lest birthdey): 62 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Yeer): JAN. 31, 1936
9. Birthplece (Stete or Foreign Country): MARYLAND

Usuel Residence ot Decedent

10e. Stete: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE CITY
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street end Number: 5814 BERKELEY AVENUE
10f. Zip Code: 21215
10g. Citizen of Whet Country?: USA.

11. Merital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Yeer or Detes: 01-31-55 to 01-3
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Rece - Americen Indien, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grede completed): Elementery/Secondary (0-12): 8 YRS; College (1-4or 5+):
16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): ADMINISTRATOR
16b. Kind of Business/Industry: BALTO CITY SCHOOLS

17. Fether's Neme (First, Middle, Lest): SOLOMON RICKS
18. Mother's Neme (First, Middle, Meiden Surneme): GRACE HAMLIN

19a. Informent's Neme/Reletionship (Type, Print): RUTH C. RICKS (WIFE)
19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 5814 BERKELEY AVENUE, BALTIMORE, MD. 21215

20a. Method ot Disposition: 1 ☒ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, crematory or other place): GARRISON FOREST
Dete: 12-04-98
20c. Locetion - City or Town, Stete: OWINGS MILLS, MD.

21. Signeture of Funerel Service Licensee: ▶ D. Brown
22. Neme end Address of Fecility: JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTIMORE, MD. 21217

Physician /Medical Examiner

23a. Pert I. Enter the diseese, or complicetions that caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert failure. List only one ceuse on eech line.

		Approximete Intervel Between Onset end Deeth
Immediete Cause (Finel diseese or condition resulting in death) e.	CARDIOGENIC SHOCK	6 HRS
Due to (or es e consequence of):		
b.	MYOCARDIAL INFARCTION	12 HRS
Sequentielly list conditions, if any, leading to immediete cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in deeth) Lest. Due to (or es e consequence of): c.	CARDIOMYOPATHY	5 YRS
d.	DIABETES MELLITUS	10 YRS

Pert II. **Other significent conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. Did tobecco uee contribute to the cauee of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probebly 4 ☐ Unknown

24e. Wes en eutopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were eutopsy findings available prior to completion ot ceuse of deeth? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Menner of Death: 1 ☒ Netural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigetion 6 ☐ Could not be determined
28e. Dete of Injury (Month, Dey Yeer)
28b. Time of Injury M
28c. Injury et Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Locetion (Street end Number or Rurel Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, dete end place, end due to the ceuse(s) end menner es steted. 2 ☐ **Medical Examiner:** On the basis ot examination end/or investigetion, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) end menner steted.

29b. Signeture end Title of certifier: ▶ R Ayash MD
29c. License number: D20111
29d. Date signed (Month, Dey, Yeer): NOV. 28, 1998

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): RAJA E. AYASH MD UNION MEMORIAL HOSP. BALT MD.

State Registrar

31. Dete filed (Month, Dey, Yeer): DEC 07 1998
32. Registrer's Signeture: ▶ G. Spark

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Menlel Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the deeth certificate be executed within 24 hours after deeth.
To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

AEG
6T1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37421

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Lest): George Rathman

2. Dete of Deeth — Month: December Dey: 01 Yeer: 1998

3. Time of Deeth: 0500 AM

4a. Feclity Name (If not institution, give street and number): Future Care Old Court

4b. City, Town, or Location of Deeth: Randallstown

4c. County of Deeth: Baltimore

Funeral Director

5. Social Security Number: 212-10-6099

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 87 Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Dey, Yeer): MAR. 8, 1911

9. Birthplace (State or Foreign Country): Maryland

Usuel Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Woodlawn

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 2135 Southland Road

10f. Zip Code: 21207

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- It Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed) — Elementary/Secondary (0-12): 12 — College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Safety Engineer

16b. Kind of Business/Industry: Auto manufacturing

17. Fether's Name (First, Middle, Last): George Edward Rathman

18. Mother's Name (First, Middle, Maiden Surneme): Theresa Heilmann

19a. Intormant's Neme/Relationship (Type, Print): Marguerite Rathman (wife)

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 2135 Southland Road, Baltimore, Maryland 21207

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removel from State 4☐ Donation 5☐ Other (Specify)

20b. Piece of Disposition (Name of cemetery, cremetory or other piece): Baltimore/Washington Crematory

Date: DEC. 3

20c. Location - City or Town, State: Laurel, Maryland

21. Signeture of Funeral Service Licensee: John Stutzman (proxy)

22. Neme end Address of Facility: Loring Byers Funeral Directors, Inc. 8728 Liberty Rd. Randallstown, Maryland 21133

Physician /Medical Examiner

25a. Part I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one ceuse on eech line.

Approximate Intervel Between Onset end Deeth

Immediate Ceuse (Final disease or condition resulting in deeth): e. Dementia

Due to (or es e consequence ot):

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Diseese or Injury thet initieted events resulting in deeth) Lest:

b. Cerebral vascular accidents

Due to (or es e consequence of):

c.

Due to (or es a consequence of):

d.

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Pert I.: Hypertention

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☑ No

24b. Were eutopsy tindings eveileble prior to completion of cause ot deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☑ No

26. Place of Deeth (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☑ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place ot Injury - At home, term, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best ot my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. 2☐ **Medicel Exeminer**: On the basis ot exeminetion end/or investigetion, in my opinion, deeth occurred et the time, date end placa, end due to the cause(s) end menner stated.

29b. Signeture end title of certifier: D Roggen MD

29c. License number: D 35844

29d. Dete signed (Month, Dey, Yeer): December 02, 1998

30. Name end eddress ot person who completed cause ot deeth (Item 23e) (Type, Print): D Roggen 5400 Old Court Road Randallstown MD 21133

State Registrar

31. Dete filed (Month, Dey, Yeer): DEC 07 1998

32. Registrer's Signeture: Geneva G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Rathman, George

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37422

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: John Rasool

2. Dete of Deeth — Month: December Day: 3 Year: 1998

3. Time of Death: 10 30 pm

4e. Facility Name *(If not institution, give street and number)*: Maryland General Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Deeth:

Funeral Director

5. Sociel Security Number: 216-36-5194

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 57 Yrs.

If Under 1 Year — Months: Deys:

If Under 24 Hrs. — Hours: Min.:

8. Date of Birth *(Month, Day, Year)*: 08 18 41

9. Birthplace *(State or Foreign Country)*: M.D.

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street end Number: 1411 Division Street

10f. Zip Code: 21217

10g. Citizen of What Country?: U.S.A.

11. Maritel Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*

Elementary/Secondary (0-12): 12th Grade

College (1-4or 5+): NA

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: A Line Man

16b. Kind of Business/Industry: General Motors

17. Fether's Neme *(First, Middle, Last)*: Isaac Fisher

18. Mother's Name *(First, Middle, Maiden Surname)*: Gertrude Stevenson

19a. Informant's Name/Reletionship *(Type, Print)*: Angela Rasool-wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4005 Belvieu Ave, Baltimore Md 21215

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cametery, crematory or other place)*: King Memorial Park

Dete: 12/5/98

20c. Location - City or Town, Stete: Randallstown, md

21. Signature of Funeral Service Licensee: Dale March

22. Name end Address of Fecility: March F/H West, 4300 Wabash Ave, Baltimore Md 21215

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications thet caused the death. Do not enter the mode of dylng, such es cardiec or respiretory errest, shock, or heert feilure. List only one cause on each line.

Approximate Interval Between Onset end Deeth

Immediate Cause (Final disease or condition resulting in death)

a. Arrhythmia Asystole

Due to (or es e consequenca of):

b. Cardiac Arrest

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Last

Due to (or es a consequenca of):

c. Acute Respiratory Failure.

Due to (or es a consequenca of):

d.

Pert II. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Pert I.

23b. **Did tobacco uae contribute to the cauae of death?** 1 ☐ **Yes** 2 ☐ **No** 3 ☐ **Probably** 4 ☑ **Unknown**

24e. Wes en eutopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings aveilable prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Piece of Death *(Check only one)*

Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☐ Residenca 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☑ Netural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28e. Dete of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Placa of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*

1 ☑ **Certifying Phyaician:** To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) end menner es steted.

2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end menner stated.

29b. Signature end title of certifier: Rashmi Pethkar M.D

29c. License number: P 12675

29d. Date signed *(Month, Day, Year)*: 12/3/98

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): Rashmi Pethkar, M.D. c/o Maryland General Hospital.

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 07 1998

32. Registrar's Signeture: Bessie B. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

permit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Haalth and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

John Rasool

Divlsion of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: Tha law requiras that tha death certificata be completed within 24 hours after daath.

To the Funeral Director: After this certificata has been signed by tha attending physician and completaly filled in by the funaral director, paga 2 should ba datached for usa as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37423

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MICHAEL ANTHONY RITTINER

2. Date of Death (Month, Day, Year): NOVEMBER 30, 1998

3. Time of Death: 10:40PM

4a. Facility Name (If not institution, give street and number): CARROLL COUNTY GENERAL HOSPITAL

4b. City, Town, or Location of Death: WESTMINSTER

4c. County of Death: CARROLL

Funeral Director

5. Social Security Number: 434-72-1174

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 50 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 11/1/48

9. Birthplace (State or Foreign Country): LOUISIANA

Usual Residence of Decedent

10a. State: MD

10b. County: CARROLL

10c. City, Town or Location: HAMPSTEAD

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 18128 GUNPOWDER ROAD

10f. Zip Code: 21074

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): MOTOR VEHICLE OPERATOR

16b. Kind of Business/Industry: U.S.P.S.

17. Father's Name (First, Middle, Last): PAUL A. RITTINER

18. Mother's Name (First, Middle, Maiden Surname): THELMA FAE

19a. Informent's Name/Relationship (Type, Print): MRS. VICTORIA E. RITTINER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 18128 GUNPOWDER RD. HAMPSTEAD, MD. 21074

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): HAMPSTEAD CEME. Date: 12/4/98

20c. Location - City or Town, State: HAMPSTEAD, MD

21. Signature of Funeral Service Licensee: Charles Kaczorowski

22. Name and Address of Facility: KACZOROWSKI FUNERAL HOME P.A. 1201 Dundalk Avenue Balto., MD 21222

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Pulmonary Emb.

Due to (or as a consequence of): hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Surgery

Due to (or as a consequence of): Sev weeks

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditiona** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was en autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were eutopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpetient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D33165

29d. Date signed (Month, Day, Year): 12/3/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Steven Strafer 2111 Hanover Pike Hampstead MD 21074

State Registrar

31. Date filed (Month, Day, Year): DEC 07 1998

32. Registrar's Signature: Jeanne G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: Tha law requires that tha death certificeta be axecuted within 24 hours after death.

To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be datachad for use es the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 90 37424

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARIAM AUDREY RICHARDS

2. Data of Death Month / Day / Year: DECEMBER 2 1998

3. Time of Death: 3:40 P.m.

4e. Facility Name *(If not institution, give street and number)*: NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death: GLEN BURNIE

4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 196-14-3416

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 85 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: JUNE 11, 1913

9. Birthplace *(State or Foreign Country)*: PENNSYLVANIA

Usual Residence of Decedent

10a. Stete: MARYLAND

10b. County: ANNE ARUNDEL

10c. City, Town or Location: GLEN BURNIE

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Numbar: 209 STIEMLY AVENUE

10f. Zip Code: 21060

10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Dacedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yas, Giva Year or Detes:

13. Was Dacedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yas 2☒ No *Specify:*

14. Race - Americen Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Eduction *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+): N/A

16e. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT usa retired)*: CLERK

16b. Kind of Business/Industry: COUNTY GOVERNMENT

17. Father's Name *(First, Middla, Last)*: MASON PARTNER

18. Mothar's Name *(First, Middle, Maidan Surname)*: ALICE HAINES

19a. Informent's Name/Relationship *(Type, Print)*: GAYLE TIQUI (NIECE)

19b. Mailing Address *(Street and Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 209 STIEMLY AVENUE, GLEN BURNIE, MD. 21060

20e. Method of Disposition: 1☒ Buriel 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or othar place)*: MEADOWRIDGE MEMORIAL PARK

Date: 12/5/98

20c. Locetion - City or Town, State: ELKRIDGE, MARYLAND

21. Signeture of Funeral Service Licensee: Michael C. Taffion

22. Name end Address of Facility: SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused tha deeth. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximate Interval Between Onset end Death

Immediete Ceuse (Final diseasa or condition resulting in death): e. UROSEPSIS

Due to (or es e consequence of):

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Lest

b. Dua to (or es e consequence of):

c. Dua to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa givan in Part I.: CORONARY ARTERY DISEASE

23b. **Did tobacco use contribute to the causa of death?** 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an eutopsy performed? 1☐ Yes 2☑ No

24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Deeth *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☑ Naturel 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Tima of Injury

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) end menner as steted. 2☐ **Medical Examiner:** On the basis of examination end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end manner stated.

29b. Signature end title of certifier: MD

29c. License number: D43977

29d. Date signed *(Month, Day, Year)*: December 2 1998

30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print): Ayoka Oretunji . 301 Hospital Drive . Glen Burnie . MD. 21061

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 07 1998

32. Registrar's Signature: Lenora G Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by tha funeral director, paga 2 should be detached for use as the burial-transit

AUDREY RICHARDS.

DHMH 16 Rev 6/95

RKD

98-6880-510

DENISE ROBBINS

ITEMS: #23 PART I, 27, 28A-F PER MEO G766 12-16-98 WR

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

98 37425

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Denise Robbins

2. Date of Death Month Day Year: NOVEMBER 25, 1998

3. Time of Death: 4:10P.M.

4a. Facility Name (If not institution, give street and number): 3439 PATON AVE

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 267-43-4088

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 39 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 6, 1959

9. Birthplace (State or Foreign Country): Florida

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 3439 Paton Avenue

10f. Zip Code: 21215

10g. Citizen of What Country? United States

11. Meritel Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1977-1977

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Elwood U. Kane, Jr.

18. Mother's Name (First, Middle, Meiden Sumeme): Lillian I. Hawkins

19a. Informant's Name/Relationship (Type, Print): Elwood U. Kane, Jr. Father

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 5044 18th Street North St. Petersburg, Florida 33714

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removel from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, crematory or other piece): Chesapeake Crematory, Inc. Date: 12/2/98

20c. Location - City or Town, State: Beltsville, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name end Address of Facility: Singleton Funeral Home, PA
1 Second Avenue, SW
Glen Burnie, Maryland 21061

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. HYDROCODONE INTOXICATION

Due to (or as e consequenca of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as e consequenca of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the causa of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Wes en eutopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? ☒ Yes 2☐ No

26. Plece of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☒ Could not be determined

28a. Date of Injury (Month, Dey Year): 11-25-98

28b. Time of Injury: UNKNOWN M

28c. Injury et Work? 1☐ Yes 2☒ No

28d. Describe how injury occurred: UNKNOWN

28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify): HOME

28f. Location (Street end Number or Rural Route Number, City or Town, Stete): 3439 PATON AVE., BALTIMORE MARYLAND

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for usa as the burial-transit

29a. Certifier (Check only one): 1☐ **Certifying Phyaician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: O.C.M.E.

29d. Date signed (Month, Dey, Year): NOVEMBER 26,1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): THEODORE McKAY 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Dey, Yeer): DEC 07 1998

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 371426

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: FRANK A. SMITH, JR.

2. Date of Death Month Day Year: DECEMBER 2, 1998

3. Time of Death: 3:33 AM

4a. Facility Name *(If not institution, give street end number)*: Saint Joseph Medical Center

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 213-30-2639

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthdey)*: 66 Yrs.

If Under 1 Yaar: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Dey, Year)*: APRIL 6, 1932

9. Birthplaca *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10e. State: MARYLAND

10b. County: HARFORD

10c. City, Town or Location: FALLSTON

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2221 WATERVALE ROAD

10f. Zip Code: 21047

10g. Citizan of Whet Country?: U.S.A.

11. Merital Stetus: 1☐ Naver Married 2☒ Married 3☐ Widowed 4☐ Divorcad

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yas 2☐ No If Yes, Give Year or Dates: KOREA

13. Was Decedent of Hispenic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Raca - Amarican Indien, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elamentary/Secondery (0-12): 12 YRS; College (1-4or 5+):

16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: LINEMAN

16b. Kind of Business/Industry: C+P TELEPHONE Co.

17. Father's Neme *(First, Middle, Last)*: FRANK A. SMITH, SR.

18. Mother's Nama *(First, Middle, Meiden Surneme)*: BLANCHE CROWDER

19a. Informant's Neme/Reletionship *(Type, Print)*: JEAN E. SMITH

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 2221 WATERVALE ROAD FALLSTON, MARYLAND 21047

20e. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*: PARKWOOD CEMETERY

Dete: DEC 5, 1998

20c. Location - City or Town, State: PARKVILLE MARYLAND

21. Signature of Funeral Service Licensee: Tony Ryan

22. Name end Address of Facility: EVANS FUNERAL CHAPEL — BEL AIR, P.A. 21050, 3 NEWPORT DRIVE FOREST HILL, MARYLAND

Physician /Medical Examiner

23a. Part1. Entar the disease, or complications that cawsed the deeth. Do not anter the moda of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Death

Immediate Cause (Final disease or condition resulting in death): a. VENTRICULAR ARRYTHMIA — HOURS

Due to (or es e consequence of): b. CONGESTIVE HEART FAILURE — DAYS

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in deeth) Last

Dua to (or es e consequence of): c. ACUTE MYOCARDIAL INFARCTION — DAYS

Dua to (or as a consaquanca of): d. CORONARY ARTERY DISEASE — YEARS

Part II. **Othar significant conditions** contributing to death but not rasulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performed? 1☐ Yas 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was casa referred to medical examiner? 1☐ Yes 2☒ No

26. Plece of Death *(Check only one)*: Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Plece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and plece, end due to tha cause(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigetion, In my opinion, death occurred et the time, date end place, and due to the cause(s) and mannar stated.

29b. Signature end title of certifier: Richard L. Lithicum MD

29c. License number: D31826

29d. Dete signed *(Month, Day, Year)*: 12-2-98

30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print): RICHARD L. LITHICUM, M.D. ST. JOSEPH MEDICAL CENTER

State Registrar

31. Dete filed *(Month, Day, Yeer)*: DEC 07 1998

32. Registrar's Signeture: Geneva B. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be distributed for use as the burial-transit

Smith, Frank A.

15

WRC
98-7015-043
GILBERT E.
STOVER

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37427

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GILBERT EUGENE STOVER, JR.
2. Date of Death (Month, Day, Year): DECEMBER 02, 1998
3. Time of Death: 12:01 PM.
4a. Facility Name (If not institution, give street and number): I 70
4b. City, Town, or Location of Death: CLEARSPRING
4c. County of Death: WASHINGTON

Funeral Director

5. Social Security Number: 215-48-6061
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 48 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): OCT. 16, 1950
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: HARFORD
10c. City, Town or Location: FALLSTON
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3416 WIDOWS LANE
10f. Zip Code: 21047
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 YRS. College (1-4or 5+): 8 YRS.
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SELF EMPLOYED - DENTIST
16b. Kind of Business/Industry: DENTISTRY

17. Father's Name (First, Middle, Last): GILBERT E. STOVER, SR.
18. Mother's Name (First, Middle, Maiden Surname): JANET I. TALBOTT

19a. Informant's Name/Relationship (Type, Print): DEBORA ANN STOVER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3416 WIDOWS LANE FALLSTON, MARYLAND 21047

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): EVANS FUNERAL CHAPEL — BEL AIR, P.A.
Date: DEC. 6, 1998
20c. Location - City or Town, State: FOREST HILL, MARYLAND

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: EVANS FUNERAL CHAPEL — BEL AIR, P.A. 21050
3 NEWPORT DRIVE FOREST HILL, MARYLAND

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
a. Multiple injuries and drowning
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Seizure Disorder

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) AT SCENE
27. Manner of Death: 1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year): 12-02-98
28b. Time of Injury: 1201 PM
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: Automobile accident
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Highway
28f. Location (Street and Number or Rural Route Number, City or Town, State) Interstate 70 Hagerstown, Maryland

29a. Certifier (Check only one): 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] Steph A Nadz, MD
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): DECEMBER 03, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): DEC 07 1998
32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

25

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37420

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Roger G. Sherman
2. Date of Death (Month, Day, Year): December 2 1998
3. Time of Death: 3:20pm
4a. Facility Name (If not institution, give street and number): Multi-Medical Nursing Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 115-28-5973
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 61 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 18 1937
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Md.
10b. County: Baltimore
10c. City, Town or Location: Parkville
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 2519 Taylor Ave.
10f. Zip Code: 21234
10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): claims manager
16b. Kind of Business/Industry: Division of Continental Insurance

17. Father's Name (First, Middle, Last): Gregory A. Slevnikov
18. Mother's Name (First, Middle, Maiden Surname): Mary E. Marvell

19a. Informant's Name/Relationship (Type, Print): Dorothy W. Sherman
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2519 Taylor Ave. Baltimore, Md 21234

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Arlington National Cem.
Date: Dec 18 1998
20c. Location - City or Town, State: Arlington, Virginia

21. Signature of Funeral Service Licensee: Keith S Wells
22. Name and Address of Facility: Evans Funeral Chapel 8800 Harford Rd. Baltimore Md 21234

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Sepsis	hours
Due to (or as a consequence of): b.	Urinary infection	1-day
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): c.	Renal & Bladder Masses of unspecified nature	
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

COPD
Diabetes
Stroke

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residenca 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) and manner es stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and placa, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D17118
29d. Data signed (Month, Day, Year): 12/03/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Paul Schwartz 115 E Melrose Ave 21212

State Registrar

31. Date filed (Month, Day, Year): DEC 07 1998
32. Registrar's Signature: John P. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

20

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item:26per M.D G-766 12/7/98 reb

Certificate of Death

Reg. No. 98 87529

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Dete of Deeth Month	Dey	Yaar	3. Time of Deeth
LEE	SAUNDERS	NOVEMBER	22	1998	9:33 P.M.

4a. Facility Name (If not institution, give street end number)	4b. City, Town, or Location of Death	4c. County of Deeth
LIBERTY MEDICAL CENTER	BALTIMORE	N/A

Funeral Director

5. Sociel Security Number	6. Sax	7. Age (In yrs. last birthday)	If Under 1 Yaar: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Data of Birth (Month, Dey, Yeer)	9. Birthplaca (State or Foreign Country)
227-20-9041	1☒ M 2☐ F	75 Yrs.					SEPT. 02, 1923	VIRGINIA

Usuel Residance of Decedent

10a. Stata	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	N/A	BALTIMORE CITY	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1914 W. NORTH AVENUE	21217	USA

11. Meritel Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuben, Mexican, Puarto Rican, atc.)	14. Race - American Indian, Bieck, White, atc.
1☐ Never Merried 2☒ Merried 3☐ Widowed 4☐ Divorced	1☐ Yas 2☒ No If Yes, Give Yaar or Detes:	1☐ Yes 2☒ No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highast greda completed)		16a. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT usa retired)	16b. Kind of Business/Industry
Elementery/Secondary (0-12)	College (1-4or 5+)		
8TH GRADE		LABORER	GRACE CHEMICAL CO.

17. Fathar's Nama (First, Middle, Last)	18. Mothar's Nama (First, Middle, Malden Sumama)
SAM SAUNDERS	BLANCHE JONES

19e. Informent's Neme/Reletionship (Type, Print)	19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Steta, Zip Code)
FRANCES SAUNDER (SISTER)	1914 W. NORTH AVENUE, BALTIMORE, MD. 21217

20e. Method of Disposition	20b. Pleca of Disposition (Neme of cemetery, cremetory or othar piece)	Date	20c. Location - City or Town, State
1☒ Buriel 2☐ Cremetion 3☐ Ramoval from State 4☐ Donation 5☐ Othar (Specify)	MT. ZION CEMETERY	11-28-98	LANSDOWNE, MD.

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Neme end Address of Feciliby: JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 2140 N. FULTON AVENUE, BALTIMORE, MD. 21217

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filled within 72 hours efter death with the Merylend Department of Health end Mentel Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part1. Enter tha disaase, or complications that caused the deeth. Do not antar the mode of dying, such as cardiac or raspiratory arrast, shock, or heert feilure. List only one ceuse on eech line.

Approximeta Interval Between Onset and Death

Immediate Cause (Finel disaase or condition resulting in deeth)
e. Acute myocardial Infarction

Due to (or es e consequence of):
b. Arteriosclerotic Heart Disease — Several years

Sequentially list conditions, if eny, leeding to Immedieta cause. Enter Underlying Ceuse (Disease or injury thet initiated events resulting in deeth) Last

Dua to (or as a consequenca of):
c. Generalized Arteriosclerosis

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause givan in Pert I.

Chronic Renal Failure
Prostate Cancer

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was en eutopsy performed?	24b. Wara eutopsy findings eveileble prior to completion of cause of deeth?
1☐ Yas 2☑ No	1☐ Yes 2☐ No

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Wes case referred to medical examiner? 1☐ Yas 2☑ No

28. Piece of Death (Check only one)
Hospitel: 1☐ Inpatient 2☒ ER/Outpetient 3☐ DOA
Other: 4☐ Nursing Homa 5☐ Residence 8☐ Other (Specify)

27. Menner of Death: 1☑ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28e. Dete of Injury (Month, Dey Yeer)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
	M	1☐ Yes 2☐ No	

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end place, and due to the ceuse(s) end menner es steted.
2☐ **Medical Examiner:** On the besis of exemination and/or investigetion, in my opinion, deeth occurred at the time, date and placa, end due to the cause(s) end menner stated.

29b. Signeture and title of certifier	29c. License number	29d. Deta signed (Month, Dey, Yeer)
▶ Colvin Cecil Carter MD.	D01459	Nov. 27, 1998

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print)
Colvin Cecil Carter 4710 Penning ton Ave. Baltimore, Maryland 21226

State Registrar

31. Deta filed (Month, Dey, Yeer)	32. Registrar's Signature
DEC 07 1998	[signature] D. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Larry Darnell Stringfield

2. Date of Death: Month Dec, Dey 02, Yeer 1998

3. Time of Death: 2430

4a. Facility Name (If not institution, give street end number): Deaton Medical Center

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 238-78-1433

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 49 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Year): 09-03-1949

9. Birthplace (State or Foreign Country): North Carolina

Usuel Residence of Decedent

10a. Stete: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore City

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street end Number: 4830 Green Crest Road

10f. Zip Code: 21206

10g. Citizen of Whet Country?: U.S.A.

11. Marital Stetus: 1 ☒ Never Merried 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No. If Yes, Give Yeer or Detes: Navy

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grede completed): Elementery/Secondary (0-12): 12th; College (1-4or 5+):

16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Electric Techincian

16b. Kind of Business/Industry: Baltimore Gas & Electric

17. Fether's Name (First, Middle, Last): Wilbert Stringfield

18. Mother's Name (First, Middle, Maiden Surneme): Ruby Lee Costin

19a. Informent's Name/Relationship (Type, Print): Elizabeth Imes/Sister

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 919 N. Wolfe Street Baltimore, Maryland 21-05

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Piece of Disposition (Name of cemetery, cremetory or other place): Arbutus Memorial Park

Date: 12/5/98

20c. Location - City or Town, Stete: Arbutus, Maryland

21. Signature of Fineral Service Licensee: Charles H. Bondell

22. Name end Address of Fecility: William C. Brown Community Funeral Home 1206 W. North Avenue, Baltimore, Maryland 21217

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on eech line.

Approximete Intervel Between Onset end Deeth

Immediete Cause (Finel diseese or condition resulting in deeth)
e. Pneumonia — 3 days.

Due to (or es e consequence of):

Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in deeth) Last
b. Multiple CVA's — 2 yrs.

Due to (or es e consequence of):
c. Acquired Immunodeficiency Syndrome

Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24e. Wes en eutopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical exeminer? 1 ☐ Yes 2 ☒ No

26. Piece of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA; Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Deeth: 1 ☒ Netural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) end menner es steted. 2 ☐ **Medical Examiner**: On the basis of exeminetion end/or investigetion, in my opinion, death occurred et the time, date end piece, end due to the cause(s) end menner stated.

29b. Signeture end title of certifier: Carla S. Alexander MD

29c. License number: D27087

29d. Date signed (Month, Dey, Year): 12/3/98

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): CARLA S. ALEXANDER, MD 29 SGREENE ST SUITE 300 BALT. MD 21201

State Registrar

31. Dete filed (Month, Day, Year): DEC 07 1998

32. Registrer's Signature: G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Stringfield, Larry

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37631

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Anna Stallman

2. Date of Death Month Day Year: December 01 1998

3. Time of Death: 6:45 AM

4a. Facility Name (If not institution, give street end number): Augsburg Lutheran Home

4b. City, Town, or Location of Death: Lochearn

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212-74-4073

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 84 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Yeer): May 10, 1914

9. Birthplace (Stete or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Lochearn

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 6811 Campfield Road

10f. Zip Code: 21207

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housekeeper

16b. Kind of Business/Industry: Domestic

17. Father's Name (First, Middle, Last): Henry Stallman

18. Mother's Name (First, Middle, Maiden Surname): Unknown Walbeck

19a. Informant's Name/Relationship (Type, Print): Ms. Debbie Mauck

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 6811 Campfield Road Baltimore, MD 21207

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, crematory or other place): Balto. Washington Crem. | Date: 12/3/98

20c. Location - City or Town, State: Laurel, Maryland

21. Signature of Funeral Service Licensee: ▶ Stephen M Jenkins

22. Name and Address of Facility: Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death)
e. Acute CVA — minutes

Due to (or as e consequence of):
b. ASCVD

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Lest

Due to (or es e consequence of):
c.

Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveilable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Sulcide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Yeer)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred et the time, date end place, end due to the ceuse(s) end manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶

29c. License number: D37573

29d. Date signed (Month, Day, Year): Dec. 2, 1998

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print): Sf. Zibell MD 7220 Park Heights Ave, Baltimore, MD 21208

State Registrar

31. Date filed (Month, Day, Year): DEC 07 1998

32. Registrar's Signature: ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

permit. Pegas 1 end 2 should be filed within 72 hours after death with the Marylend Department of Heelth end Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Anna Stallman
Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use es the burial transit

Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37432

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Gladys J. Simms

2. Dete of Deeth — Month: Dec. Day: 3 Year: 1998

3. Time of Death: 12:45 pm

4a Feciity Neme *(If not institution, give street end number)*: Bon Secour Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Deeth: NA

Funeral Director

5. Social Security Number: 218-62-5744

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 87 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Dey, Year)*: 06 17 11

9. Birthplece *(Stete or Foreign Country)*: M.D.

Usuel Residence of Decedent

10e. Stete: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 3201 Mondawmin Ave

10f. Zip Code: 21216

10g. Citizen of Whet Country?: U.S.A.

11. Maritel Status: 1☐ Never Married 2☐ Married ☒☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indien, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 grade; College (1-4or 5+): na

16e. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Foster Care Provider

16b. Kind of Business/Industry: Foster Care

17. Fether's Neme *(First, Middle, Last)*: Rev. James Layton Williams

18. Mother's Name *(First, Middle, Maiden Surname)*: Sally Smith

19a. Informent's Name/Reletionship *(Type, Print)*: Sally A. Coates-Daughter

19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 3201 Mondawmin Ave, Balto Md 21216

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removel from State 4☐ Donation 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Arbutus Memorial Park

Dete: 12/7/98

20c. Location - City or Town, Stete: Arbutus, Md

21. Signeture of Funeral Service Licensee: Gabrielle Cook

22. Neme end Address of Facility: March F/H West, 4300 Wabash Ave, Baltimore Md 21215

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List *only* one ceuse on eech line.

Approximate Intervel Between Onset end Deeth

Immediate Ceuse (Final disease or condition resulting in death)

e. Hepatocellular carcinoma

Due to (or es e consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Lest

b.

Due to (or es e consequence of):

c.

Due to (or es e consequenca of):

d.

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Pert I.: Acute cholecystitis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

26. Piece of Deeth *(Check only one)*: Hospitel: 1☒ Inpetient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Date of Injury *(Month, Dey Year)*

28b. Time of Injury

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the besis of examination end/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier: CDKearney MD

29c. License number: D27860

29d. Date signed *(Month, Dey, Year)*: December 3, 1998

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): CHRISTOPHER D. KEARNEY 700 WASH BLVD. BALT MD 21230

State Registrar

31. Dete filed *(Month, Dey, Year)*: DEC 07 1998

32. Registrer's Signature: JoAnn G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

GRACE STOCK

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Grace May Stock

2. Date of Death Month: December Day: 2 Year: 1998

3. Time of Death: 10:30 pm

4a. Facility Name *(If not institution, give street and number)*: SINAI HOSPITAL

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

Funeral Director

5. Social Security Number: 217-12-8933

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 76 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 3, 1922

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County:

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 204 North Streeper Street

10f. Zip Code: 21224

10g. Citizen of What Country?: United States

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Accountant

16b. Kind of Business/Industry: Exxon Corporation

17. Father's Name *(First, Middle, Last)*: John Stock

18. Mother's Name *(First, Middle, Maiden Surname)*: Mary E. Cunningham

19a. Informant's Name/Relationship *(Type, Print)*: Phyllis Prokopovich - Niece

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 645 Miranda Drive Pittsburgh, Pennsylvania 15241

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Oaklawn Cemetery

Date: Dec.7,1998

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Donald R. Watson Jr.

22. Name and Address of Facility: Leonard J. Ruck, Inc. 5305 Harford Road Balto.,Md. 21214

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) a. Pulmonary Embolism (multiple)

Due to (or as a consequenca of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

Stroke

Diabetes

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*:

28b. Time of Injury: M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred:

28e. Place of Injury - At home, farm, street, factory, offica building, etc. *(Specify)*:

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*:

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted.

29b. Signature and title of certifier: ▶ Carla Watson - resident

29c. License number: P12344

29d. Date signed *(Month, Day, Year)*: DECEMBER 2, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Carla P. Watson, M.D. 2401 W. Belvedere Ave. Baltimore, MD 21215

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 07 1998

32. Registrar's Signature: ▶ Geneva G. Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, [illegible]

10

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37634

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Stephen John Sczepanski

2. Date of Death Month Dey Year: DECEMBER 3 1998

3. Time of Death: 3:20 am

4a. Facility Name *(If not institution, give street and number)*: GREATER BALTIMORE MEDICAL CENTER

4b. City, Town, or Location of Death: TOWSON

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 205-10-3022

6. Sex: 1☐ M 2☐ F — X

7. Age *(In yrs. last birthday)*: 78 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Dey, Year)*: 11-25-1920

9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. Stete: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No — XX

10e. Street and Number: 6207 Marlora Road

10f. Zip Code: 21239

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? XX Yes 2☐ No — If Yes, Give Yeer or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No — XX — Specify:

14. Race - American Indian, Black, White, etc. — Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12 Years; College (1-4or 5+): N/A

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Post Office Clerk

16b. Kind of Business/Industry: U. S. Government

17. Father's Name *(First, Middle, Last)*: Anthony Sczepanski

18. Mother's Name *(First, Middle, Maiden Surname)*: Violet Macoskie

19a. Intormant's Name/Relationship *(Type, Print)*: Marie E. Sczepanski

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 6207 Marlora Road Baltimore, Maryland 21239

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stete 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: Parkwood Cemetery

Date: 12-7-98

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: J. Wayne Osterling

22. Name and Address of Facility: Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarctn

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Pneumonia

Disseminated Intravascular Coagulatn

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☑ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospitel: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) end manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: Attending Neal M. Friedlander, MD Pham

29c. License number: 028367 MD

29d. Date signed *(Month, Day, Year)*: Dec 4, 1998

30. Neme end address of person who completed cause of death (Item 23a) (Type, Print): NEAL M. FRIEDLANDER, M.D., 6565 N. Charles St, Suite 207, Balte, Md 21204

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 07 1998

32. Registrar's Signature: Jeanne G. Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Sczepanski, Stephen

6+1

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ORIGINAL

RKD
98-7066-005

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

STEVEN
SCALES ITEMS: #23 PART I, 27, 28A-F PER MEO G766 12-11-98 WR

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37435

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
STEVEN R. SCALES	DECEMBER 3, 1998	6:22 P.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
ST. JOSEPH HOSPITAL	TOWSON	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-88-3102	X 1 M 2 F	36 Yrs.			Sept. 29 1962	MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	NA	BALTIMORE	1 X Yes 2 No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
527 WALKER AVE	21212	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 X Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 X No If Yes, Give Year or Dates:	1 Yes 2 X No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th	NA	HEAD COOK	IHOP - RESTAURANT

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
ROBERT SCALES	MARY COLE

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
RODNEY SCALES - BROTHER	1628 NORTHBOURNE RD BALTO., MD 21239

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	KING MEMORIAL PARK	12-9-98	RANDALLSTOWN, MD

21. Signature of Funeral Service Licensee: Glynn B. Harris

22. Name and Address of Facility: MARCH FUNERAL HOME WEST, inc. 4300 WABASH AVE., BALTO., MD 21215

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. NARCOTIC AND COCAINE INTOXICATION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 X Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 X Yes 2 No	1 X Yes 2 No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 X Yes 2 No	Hospital: 1 Inpatient 2 X ER/Outpatient 3 DOA	Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 Natural 2 Accident 3 Suicida 4 Homicida 5 Pending investigation 6 X Could not be determined	Found: 12-3-98	Found: M 12-3-98	1 Yes 2 X No	UNKNOWN

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): FOUND AT HOME

28f. Location (Street and Number or Rural Route Number, City or Town, State): 527 WALKER AVE.

29a. Certifier (Check only one)
1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end menner as stated.
2 X **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceusa(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
J. Pestaner, M.D	O.C.M.E.	DECEMBER 4, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Data filed (Month, Day, Year)	32. Registrar's Signature
DEC 07 1998	G. Sparks

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Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37436

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Audrey Sewell

2. Date of Death: Month 12 Day 5 Year 98

3. Time of Death: 7:40pm

4a. Facility Name *(If not institution, give street and number)*: Long View Nursing Center

4b. City, Town, or Location of Death: Manchester

4c. County of Death: Carroll Co.

Funeral Director

5. Social Security Number: 216-10-3004

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 94 Yrs.

If Under 1 Year: Months ____ Days ____

If Under 24 Hrs.: Hours ____ Min. ____

8. Date of Birth *(Month, Day, Year)*: Mar. 20, 1904

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Carroll

10c. City, Town or Location: Manchester

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 3332 Mainstreet

10f. Zip Code: 21102

10g. Citizen of Whet Country?: U.S.A

11. Maritel Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Office Manager

16b. Kind of Business/Industry: Modern Furniture House

17. Father's Name *(First, Middle, Last)*: Elbert Windsor

18. Mother's Name *(First, Middle, Maiden Surname)*: Edith Shane

19a. Informent's Name/Reletionship *(Type, Print)*: Robert Sewell (Son)

19b. Mailing Address *(Street and Number or Rurel Route Number, City or Town, State, Zip Code)*: 13918 Old Hanover Rd, Reisterstown, Md 21136

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other piece)*: Lorraine Park Cemetery

Date: 12/9/98

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funerel Servica Licansee: A. Alan Seitz Jr

22. Name end Address of Facility: A. Alan Seitz, Jr. Funeral Home 3818 Roland Avenue, Baltimore, Maryland 21211

Physician /Medical Examiner

23e. Pert1. Enter the diseese, or complicetions thet caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failure. List only one ceuse on each line.

Approximete Interval Between Onset end Death

Immediate Ceuse (Finel diseese or condition resulting in deeth) e. Alzheimers Dementia — Due to (or es e consequence of): — Yeers

Sequentielly list conditions, if eny, leading to immediete cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Lest

b. ____ Due to (or es e consequenca of): ____

c. ____ Due to (or es e consequenca of): ____

d. ____

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 1☐ Yes 2☒ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Plece of Deeth *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residenca 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Placa of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physicfan:** To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner as steted. 2☐ **Medical Examiner:** On the basis of exemination end/or Investigetion, in my opinion, death occurred et the time, date end placa, end due to the ceuse(s) end menner stated.

29b. Signeture end title of certifier: [signature]

29c. License number: D33165

29d. Date signed *(Month, Day, Year)*: 12/5/98

30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print): Steve Stather 2111 Hanover Pike Hampstead MD 21074

State Registrar

31. Dete filed *(Month, Day, Year)*: DEC 07 1998

32. Registrer's Signeture: Georgia D. Sparks

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Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

WR 6

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37437

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Charles Selander
2. Date of Death (Month, Day, Year): December 2 1998
3. Time of Death: 12:08pm
4a. Facility Name (If not institution, give street and number): Good Samaritan Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: City

Funeral Director

5. Social Security Number: 217-07-5959
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs./last birthday): 80 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 22, 1918
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 2603 Beechland Avenue
10f. Zip Code: 21214
10g. Citizen of What Country?: U.S.A

11. Marital Status: 1 [ ] Never Married [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): unknown; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Bus Driver
16b. Kind of Business/Industry: M.T.A
17. Father's Name (First, Middle, Last): Charles W. Selander
18. Mother's Name (First, Middle, Maiden Surname): Frances Hannon
19a. Informant's Name/Relationship (Type, Print): Myrtle Selander (Wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2603 Beechland Avenue, Baltimore, Maryland 21214
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Dulaney Valley Mem Gdns
Date: 12/5/98
20c. Location - City or Town, State: Timonium, Maryland
21. Signature of Funeral Service Licensee: A. Alan Seitz, Jr.
22. Name and Address of Facility: A. Alan Seitz, Jr. Funeral Home 3818 Roland Avenue, Baltimore, Md 21211

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Ventricular Fibrillation — 20min
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b. Endstage Coronary Disease
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Edmond A. Seitz MD
29c. License number: D38956
29d. Date signed (Month, Day, Year): December 2, 1998
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Edward Allen Seidel MD, 5601 Loch Raven Blvd, Baltimore MD 21239

State Registrar

31. Date filed (Month, Day, Year): DEC 07 1998
32. Registrar's Signature: G. Sparks

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

UR 10

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37438

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James W. Sheppard
2. Data of Death: Month December Day 5th Year 1998
3. Time of Death: 09:18 AM
4a. Facility Name (If not institution, give street and number): Montgomery General Hospital
4b. City, Town, or Location of Death: Olney
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 224-14-7990
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 89 Yrs. — If Under 1 Yaar: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Yaar): Sept. 8, 1909
9. Birthplaca (Stata or Foreign Country): Virginia

Usual Rasidance of Decedant

10a. Stata: Maryland
10b. County: Prince George
10c. City, Town or Location: Hyattsville
10d. Inside City Limits: 1 [ ] Yas 2 [X] No
10e. Street and Number: 1005 Chillum Road # 418
10f. Zip Code: 20782
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Navar Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedant Evar in U.S. Armed Forcas? 1 [ ] Yas 2 [X] No — If Yas, Giva Yaar or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 1 [ ] Yas 2 [X] No Specify:
14. Race - Amarican Indian, Black, White, atc. Specify: Black

15. Decedant's Education (Specify only highast grada complatad): Elementary/Secondary (0-12): 7th — College (1-4or 5+):
16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired): Cement Finisher
16b. Kind of Businass/Industry: Paving Company

17. Fathar's Nama (First, Middle, Last): Edward Sheppard
18. Mothar's Nama (First, Middle, Maiden Surname): Annie Newman

19a. Informant's Name/Ralationship (Type, Print): Florence Sheppard
19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code): 1005 Chillum Road #418 Hyattsville, Md 20782

20a. Mathod of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Ramoval from Stata 4 [ ] Donation 5 [ ] Othar (Specify)
20b. Place of Disposition (Nama of cematary, cramatory or othar place): Pleasant Valley Memorial Pk — Data: 12/12/98
20c. Location - City or Town, Stata: Annandale, Va.

21. Signature of Funeral Service Licensee: Robert B Baker Jr.
22. Nama and Addrass of Facility: Chinn Funeral Service, 2605 So. Shirlington Rd. Arl. Va. 22206

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that causad tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on aach line.

Approximata Intarval Batwaan Onsat and Death

Immediata Causa (Final disaasa or condition resulting in death)
a. SEPSIS — 10 days
Dua to (or as a consaquanca of):

Sequantially list conditions, if any, laading to immadiata causa. Enter Underlying Ceusa (Disaasa or injury that initiatad avants rasulting in death) Last
b.
Dua to (or as a consaquanca of):
c.
Dua to (or as a consaquanca of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa given in Part I.: Alzheimer's disease

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yas 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yas 2 [ ] No

25. Was casa rafarrad to medical examinar? 1 [ ] Yas 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatiant 2 [ ] ER/Outpatiant 3 [ ] DOA — Othar: 4 [ ] Nursing Hama 5 [ ] Rasidance 6 [ ] Othar (Specify)

27. Mannar of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Panding investigation 6 [ ] Could not be datarmined
28a. Data of Injury (Month, Day Yaar):
28b. Tima of Injury: N/A M
28c. Injury at Work? 1 [ ] Yas 2 [ ] No
28d. Dascribe how injury occurred:
28a. Placa of Injury - At home, farm, streat, factory, office building, atc. (Specify):
28f. Location (Street and Number or Rural Routa Number, City or Town, Stata):

29a. Cartifiar (Check only one): 1 [X] **Certifying Physician:** To tha best of my knowledga, daath occurrad at tha time, data and placa, and due to tha cause(s) and mannar as stated. 2 [ ] **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at tha time, data and placa, and due to the cause(s) and mannar stated.

29b. Signatura and Itla of cartifiar: Rahul Gilotra MD
29c. Licansa number: D32417
29d. Date signed (Month, Day, Yaar): December 5th, 1998

30. Nama and addrass of parson who complatad causa of daath (Item 23a) (Type, Print): Rahul Gilotra M.D. 12016 Georgia Avenue Wheaton MD 20902

State Registrar

31. Data filed (Month, Day, Yaar): DEC 07 1998
32. Registrar's Signatura: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiena.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requiras that the death certificate be executed within 24 hours aftar death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37439

SMERDZINSKI, FELIX

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year		3. Time of Death			
Felix		Smerdzinski	DECEMBER 4, 1998		3:50AM			
4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death		4c. County of Death			
Stella Maris at Mercy Hospice			Baltimore		NA			
5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)		
220-14-9720	1☐M 2☐F	72 Yrs.			Nov. 18 26	Maryland		
Usual Residence of Decedent								
10a. State	10b. County	10c. City, Town or Location			10d. Inside City Limits			
Maryland	Baltimore	Catonsville			1☐Yes 2☒No			
10e. Street and Number		10f. Zip Code			10g. Citizen of What Country?			
1 Summit Hill Ct. C-4		21228			U.S. of America			
11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			14. Race - American Indian, Black, White, etc.			
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:			Specify: White			
15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business/Industry			
Elamentary/Secondary (0-12): 12	College (1-4or 5+): NA	Proprietor			Crab Restuarant			
17. Father's Name (First, Middle, Last)			18. Mother's Name (First, Middle, Maiden Surneme)					
Stanley Smerdzinski			Josephine Unknown					
19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)						
Ilga Smerdzinski (WIFE)		1 Summit Hill Ct. C-4 Catonsville, Maryland 21228						
20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State					
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Holy Rosary	Dec. 7	Dundalk, Maryland					
21. Signature of Funeral Service Licensee		22. Name and Address of Facility						
▶ Mark A. Chojnacki		W. Dabrowski-Chojnacki F.H.'s P.A. 1005 Dundalk Ave. Balto., Md. 21224						

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or haart failure. List only one cause on eech line. — Approximate Interval Between Onset and Death

Immediate Cause (Final diseese or condition resulting in death): a. Metastatic Fibrohistic cytoma — 5 months

Due to (or es a consequence of):

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disaase or injury that initieted events resulting in death) Last:

b. Due to (or es e consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Wes en autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings availeble prior to completion of cause of death? 1☐Yes 2☐No

25. Was casa referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) Hospice — STELLA MARIS AT MERCY

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28e. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? 1☐Yes 2☐No | 28d. Describe how injury occurred

28a. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) end mennar as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, data end piece, end due to the cause(s) and menner stated.

29b. Signeture and title of cartifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature]	D40854	DECEMBER 4, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAVID RISEBERG MD 301 St Paul Pl, BALTIMORE, MD 21202

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 07 1998	[signature] B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

98-7092-510
DDG
VERONICA SCHAUMAN

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37440

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Veronica K. Schauman
2. Date of Death (Month, Day, Year): DECEMBER 5, 1998
3. Time of Death: 0124 AM
4a. Facility Name (If not institution, give street and number): 1111 SOUTH POTOMAC STREET
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death:

Funeral Director

5. Social Security Number: 215-40-6847
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 56 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 8/11/42
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1111 South Potomac Street
10f. Zip Code: 21224
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Francis Kilian
18. Mother's Name (First, Middle, Maiden Surname): Veronica Lorbeicki

19a. Informant's Name/Relationship (Type, Print): Thomas R. Schauman/husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1111 South Potomac Street Baltimore, Maryland 21224

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): St. Stanislaus Cemetery | Date: 12/9/98
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Juanita R Thomas
22. Name and Address of Facility: John C. Miller, Inc. 6415 Belair Road Baltimore, Maryland 21206

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or raspiratory arrast, shock or heart failure. List only one cause on each line. | Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death): a. Fatty Liver
Due to-(or es a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due lo (or as a consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? Partial 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to compilation of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at tha tima, data and place, and dua to tha causa(s) and mannar es stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred et tha tima, data and place, and dua to tha cause(s) and manner stated.
29b. Signature and title of certifier
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): DECEMBER 5, 1998
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David R Fowler 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): DEC 07 1998
32. Registrar's Signature: Jenna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37[illegible]

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Reynolds Hoffman Tipton

2. Date of Death Month Dey Yeer: November 30 1998

3. Time of Death: 3:55 AM

4e. Facility Neme *(If not Institution, give street end number)*: St. MAry's Hospital

4b. City, Town, or Location of Death: Leonardtown

4c. County of Deeth: St. MAry's

Funeral Director

5. Socisl Security Number: 216-18-0538

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. lest birthday)*: 89 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Yeer)*: June 3 1909

9. Birthplace *(State or Foreign Country)*: Maryland

Usuel Residence ot Decedent

10e. Stete: Md.

10b. County: Baltimore

10c. City, Town or Location: Middle River

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 3708 Lambson Road

10f. Zip Code: 21220

10g. Citizen of Whet Country?: USA

11. Maritel Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Detes:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indien, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th; College (1-4or 5+):

16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Constable

16b. Kind of Business/Industry: Baltimore City

17. Fether's Name *(First, Middle, Last)*: John Reynolds

18. Mother's Name *(First, Middle, Maiden Surname)*: Anna Hoffman

19a. Informent's Neme/Relationship *(Type, Print)*: Lee Tipton / son

19b. Mailing Address *(Street and Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 3708 Lambson Road Baltimore Md. 21220

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel trom State 4☐ Donetion 5☐ Other *(Specify)*

20b. Place ot Disposition *(Neme of cemetery, crematory or other place)*: Oak LAwn Cemetery

Dete: 12/3/98

20c. Location - City or Town, State: Baltimore Md.

21. Signature of Funerel Service Licensee: R. Terry Connelly

22. Name end Address of Feciility: Connelly Funeral Home of Essex 300 Mace AVe. Baltimore MD. 21221

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart tailure. List only one cause on each line.

Approximete Intervel Between Onset end Deeth

Immediate Cause (Final disease or condition resulting in deeth)

a. Probable Aspiration Pneumonia

Due to (or es e consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest

b. Chronic lung disease

Due to (or es a consequenca of):

c.

Due to (or es a consequence ot):

d.

Part II. **Other elgnificant conditione** contributing to deeth but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveilable prior to completion ot cause ot deeth? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Plece ot Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner ot Deeth: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*:

28b. Time of Injury: M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred:

28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*:

28f. Location *(Street end Number or Rurel Route Number, City or Town, State)*:

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best ot my knowledge, death occurred et the time, dete end plece, end due to the cause(s) end menner es steted. 2☐ **Medical Examiner:** On the basis ot exemination and/or Investigetion, In my opinion, deeth occurred et the time, date end place, end due to the cause(s) end manner stated.

29b. Signature end title of certifier:

29c. License number: D14245

29d. Date signed *(Month, Day, Year)*: 11-30-98

30. Name end address ot person who completed cause of death (Item 23a) (Type, Print): WILLIAM D. BOYD II M.D BOX 1753 LEONARDTOWN,MD. 20650

State Registrar

31. Dete tiled *(Month, Day, Year)*: DEC 07 1998

32. Registrer's Signeture:

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

REYNOLDS TIPTON

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): DORTHLEA TAKACS
2. Dete of Death (Month, Day, Year): DECEMBER 1, 1998
3. Time of Death: 5:13PM
4a. Fecility Neme (If not institution, give street end number): HOPKINS BAYVIEW MEDICAL CENTER
4b. City, Town, or Location of Deeth: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 233-56-4097
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 62 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Day, Year): 6/20/36
9. Birthplece (State or Foreign Country): WEST VA.

Usuat Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: DUNDALK
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2915 YORKWAY
10f. Zip Code: 21222
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grede completed): Elementery/Secondary (0-12): 12 | College (1-4or 5+): 0
16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): WAITRESS
16b. Kind of Business/Industry: CATERING

17. Fether's Neme (First, Middle, Last): EARL SINSEL
18. Mother's Name (First, Middle, Maiden Surname): GENEVIEVE DOBBINS

19a. Informent's Neme/Relationship (Type, Print): MR. STEVE TAKACS
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 2915 YORKWAY BALTIMORE, MD. 21222

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other piece): ST. ANDREWS CEME. Dete: 12/5/98
20c. Location - City or Town, Stete: DUNDALK, MD.

21. Signature of Funeral Service Licensee: ▶ Charles Kaczorowski
22. Name and Address of Facility: KACZOROWSKI FUNERAL HOME P.A. 1201 DUNDALK AVE. BALTIMORE, MD. 21222

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on eech line.

		Approximate Intervel Between Onset end Deeth
Immediate Ceuse (Finel disease or condition resulting in death) a.	Sepsis	1 day
Due to (or as a consequence of): b.	Bowel Perforation	1 day
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting In death) Lest — Due to (or es e consequence of): c.	Bowel Ischemia	3 days
Due to (or as e consequence of): d.	Peripheral Vascular Disease	10 years

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given In Pert I.: Acute Liver Failure

23b. Did tobacco use contribute to the cauee of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings aveilable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Naturet 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Phyelcian**: To the best of my knowledge, death occurred et the time, dete end place, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner**: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end placa, and due to the cause(s) end manner stated.

29b. Signature end title of certifier: ▶ Alix Lanoue M.D.
29c. License number: RES-000
29d. Date signed (Month, Day, Year): December 1, 1998

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print): ALIX LANOUE M.D. Tower 110 Johns Hopkins Hospital Balto, MD.

State Registrar

31. Date filed (Month, Day, Year): DEC 07 1998
32. Registrar's Signature: ▶ G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Menial Hygiene.
Important: If item 27 is marked other than "naturel", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

DHMH 16 Rev 6/95

98-7102-510
wlc
MARKEL WARD

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37443

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARKEL L. WARD
2. Date of Death (Month, Day, Year): December 5, 1998
3. Time of Death: 612p
4a. Facility Name (If not institution, give street and number): UNIVERSITY OF MD MEDICAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 237-45-8548
6. Sex: 1 ☑ M 2 ☐ F
7. Age (In yrs. last birthday): 12 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): October 6, 1986
9. Birthplace (State or Foreign Country): N. CAROLINA

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 ☑ Yes 2 ☐ No
10e. Street and Number: 906 N. Franklintown Rd.
10f. Zip Code: 21216
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Student
16b. Kind of Business/Industry: N/A

17. Father's Name (First, Middle, Last): Terry Ganiley
18. Mother's Name (First, Middle, Maiden Surname): ALTINA WARD
19a. Informant's Name/Relationship (Type, Print): ALTINA WARD - mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 906 N. Franklintown Rd. Balto., MD. 21216

20a. Method of Disposition: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Murrell Hill Cemetery
Date: 12-12-98
20c. Location - City or Town, State: Jacksonville, NC.
21. Signature of Funding Service Licensee: Gary P. March
22. Name and Address of Facility: GARY P. MARCH FUNERAL HOME 2270 FREDERICK PASS, BALTO., MD 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Multiple Gunshot Wounds
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☑ Yes 2 ☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☑ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☑ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day, Year): Found 12/5/98
28b. Time of Injury: 1700 HR
28c. Injury at Work? 1 ☐ Yes 2 ☑ No
28d. Describe how injury occurred: Subject Shot
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Street
28f. Location (Street and Number or Rural Route Number, City or Town, State): 2300 Edmondson Avenue Baltimore Maryland

29a. Certifier (Check only one): 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Theodore M. Kyros
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): December 6, 1998
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): THEODORE M. Kyros 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): DEC 07 1998
32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37444

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Jean Wiley

2. Dete of Deeth Month Dey Yeer: December 3, 98

3. Time of Death: 10:40 am

4e. Fecility Neme (If not institution, give street end number): Charlestown Care Center

4b. City, Town, or Location of Deeth: Catonsville

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 218-09-0586

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. lest birthday): 79 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Yeer): DEC.17,1918

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Catonsville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 709 Maiden Choice Lane

10f. Zip Code: 21228

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed): Elementery/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Clayton J. Larash

18. Mother's Name (First, Middle, Meiden Surname): Edna Reading

19e. Informent's Name/Reletionship (Type, Print): Plummer Wiley (husband)

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 709 Maiden Choice Lane, Catonsville, MD. 21228

20e. Method of Disposition: 1☐ Burial 2☐ Cremetion 3☐ Removal from Stete 4☐ Donetion 5☒ Other (Specify) entombment

20b. Piece of Disposition (Neme of cemetery, cremetory or other place): Woodlawn Cemetery

Dete: DEC.7

20c. Location - City or Town, State: Woodlawn, Maryland

21. Signature of Funeral Service Licensee: John Stacy (proxy)

22. Neme end Address of Fecility: Loring Byers Funeral Directors, Inc. 8728 Liberty Road, Randallstown, Maryland 21133

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one ceuse on eech line.

Approximate Intervel Between Onset end Deeth

Immediate Ceuse (Finel diseese or condition resulting in death): e. End Stage Dementia — Years

Due to (or es e consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in deeth) Lest:

b.

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☑ No

24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 1☐ Yes 2☑ No

25. Wes case referred to medical examiner? 1☐ Yes 2☑ No

28. Piece of Deeth (Check only one): Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Yeer)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the beeis of exeminetion end/or Investigation, in my opinion, death occurred et the time, dete end piece, end due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier: Andres Salazar MD

29c. License number: D51051

29d. Dete signed (Month, Dey, Yeer): December 3, 1998

30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print): Andres Salazar 711 Maiden Choice Lane, Catonsville, MD, 21228

State Registrar

31. Dete filed (Month, Day, Year): DEC 07 1998

32. Registrer's Signature: D. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificete be executed within 24 hours after death.

To the Funeral Director: After this certificete has been signed by the attending physician and completely filled in by the funeral director, pege 2 should be detached for use es the burial-transit

Name: Jean Wiley

6

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: KATHLEEN M. WOOD

2. Date of Death Month / Dey / Year: DEC. 5 1998

3. Time of Death: 6:45 am

4a. Facility Neme *(If not institution, giva street and number)*: 1402 BurkeRoad

4b. City, Town, or Location of Death: Bowleys Quarters

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 219-16-6582

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 76 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Dey, Year)*: April 29 1922

9. Birthplace *(State or Foreign Country)*: Maryland

Usuel Residence of Decedent

10a. State: Md.

10b. County: Baltimore

10c. City, Town or Location: Bowleys Quarters

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1402 Burke Road

10f. Zip Code: 21220

10g. Citizen of Whet Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedant Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, atc. *Specify:* White

15. Decedent's Education *(Specify only highest grada completad)*: Elementery/Secondary (0-12): 12th / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working life. DO NOT use retired)*: HOmemaker

16b. Kind of Business/Industry: own home

17. Fathar's Nama *(First, Middle, Last)*: Joseph Devine

18. Mother's Name *(First, Middle, Maiden Surnema)*: Madeline Trenner

19a. Informant's Name/Relationship *(Type, Print)*: MAlcolm H. Wood / son

19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stete, Zip Code)*: 1505 East North Ave. Baltimore Md. 21213

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Holly Hill Cemetery

Date: 12/7/98

20c. Location - City or Town, State: Baltimore Md.

21. Signature of Funerel Service Licensee: R. Terry Connelly

22. Name and Address of Facility: Connelly Funeral Home of Essex, 300 Mace AVe. Baltimore Md. 21221

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the moda of dying, such as cerdiac or raspiratory arrest, shock, or heart failura. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Hypercalcemia — 1 month

Due to (or as a consequence of): Breast Cancer — 3 years

Sequantially list conditions, if any, leading to immediata ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last

b. Due to (or as a consequence of):

c. Due to (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yee 2☒ No 3☐ Probably 4☐ Unknown

24e. Was en eutopsy performed? 1☐ Yas 2☒ No

24b. Were autopsy findings avallable prior to completion of cause of deeth? 1☐ Yes 2☒ No

25. Was case referred to medicel examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Mannar of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Routa Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2☐ **Medicel Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end piece, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: Eric DeJonge MD

29c. License number: D43427

29d. Date signed *(Month, Dey, Year)*: 12/7/98

30. Nama and address of person who completed ceuse of death (Item 23a) (Type, Print): Eric DeJonge, M.D. Johns Hopkins Geriatrics Center

State Registrar

31. Data filed *(Month, Day, Year)*: DEC 07 1998

32. Registrar's Signature: James G. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

5

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37446

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): PATRICIA WAGNER
2. Date of Death (Month, Day, Year): December 1 1998
3. Time of Death: 12:07
4a. Facility Name (If not institution, give street and number): The Johns Hopkins Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-40-5015
6. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthday): 55 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 9, 1943
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Eastwood
10d. Inside City Limits: 1☐ Yes 2☑ No
10e. Street and Number: 7245 Conley Street
10f. Zip Code: 21224
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☑ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Seamstress
16b. Kind of Business/Industry: Clothing

17. Father's Name (First, Middle, Last): Leo Everd
18. Mother's Name (First, Middle, Maiden Surname): Louise Daley

19a. Informant's Name/Relationship (Type, Print): Richard A. Wagner / husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7245 Conley Street Baltimore, Maryland 21224

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Oak Lawn Cemetery
Date: 12/5/98
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: David J. Weber
22. Name and Address of Facility: David J. Weber Funeral Homes, P.A. 401 S. Chester Street Baltimore, Maryland 21231

Physician /Medical Examiner

23a. Part I. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	INTRACRANIAL Bleed	1 day
Due to (or as a consequence of): b.	Right Ischemic Leg	2 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	Peripheral Vascular disease	15 years
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: RES 000
29d. Date signed (Month, Day, Year): December 01, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen Aufderheide 600 North Wolfe Street Baltimore, Maryland 21287-9105

State Registrar

31. Date filed (Month, Day, Year): DEC 07 1998
32. Registrar's Signature: Penny G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37447

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Maryanna Waszkiewicz
2. Data of Death (Month, Day, Year): December 1, 1998
3. Time of Death: 8:20PM
4a. Facility Name *(If not institution, giva street and number)*: Canton Harbor Healthcare
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-01-6677
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 99 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: Jan.20,1899
9. Birthplaca *(Stata or Foreign Country)*: Germany

Usual Rasidence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yas 2☐ No
10e. Street and Number: 636 S. Linwood Avenue
10f. Zip Code: 21224
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yes 2☒ No — If Yes, Give Yaar or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specity Cuban, Mexican, Puarto Rican, atc.) 1☐ Yas 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Spacify only highast grade completad)*: Elementary/Secondary (0-12): 6th — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working lifa. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: N/A

17. Father's Name *(First, Middle, Last)*: Frank Sobczak
18. Mother's Name *(First, Middle, Maiden Sumame)*: Unknown Markiewicz

19a. Informent's Name/Relationship *(Type, Print)*: Eleanor Kropfelder/Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 5 Gandson Ct. Unit 302 Timonium, Maryland 21093

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Holy Rosary Cemetery
Date: 12/5/98
20c. Location - City or Town, State: Baltimore

21. Signature of Funeral Servica Licensee: ▶ Kathleen Weber CFSP
22. Name and Address of Facility: David J. Weber Funeral Homes, P.A. 401 S. Chester St. Baltimore, Maryland 21231

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that causad the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disaase or condition resulting in death)
a. Carcinoma of the parotid gland — 6 months
Due to (or as a consequence of): with Metastasis

Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initieted events rasulting in death) Last
b. ____ Due to (or as e consequence of): ____
c. ____ Dua to (or as a consequence of): ____
d. ____

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Arteriosclerotic Heart Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Ware autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Homa 5☐ Residence 6☐ Othar *(Specify)*

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending invastigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Placa of tnjury - At home, ferm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as steted. 2☐ **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date end ptace, end due to the cause(s) end menner steted.

29b. Signature and title of certifier: ▶ Melito M. Torres
29c. License number: D11150
29d. Date signed *(Month, Day, Year)*: 12/3/1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MELITO M. TORRES, MD 441 S. ELLWOOD AVE, BALTO, MD 21224

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State Registrar

31. Date filed *(Month, Day, Year)*: DEC 07 1998
32. Registrar's Signatura: ▶ [illegible] G. Sparks

DHMH 16 Rav 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use at the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37440

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Louis Zito

2. Date of Death: Month: Dec Day: 5 Year: 1998

3. Time of Death: 11:00 A.M.

4a. Facility Name (If not institution, give street and number): Good Sam. Hosp. 5601 Loch. Raven Blvd.

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore city

Funeral Director

5. Social Security Number: 218-03-2084

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 80 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 10-15-1918

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Essex

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street end Number: 809 Cedar Grove Road

10f. Zip Code: 21221

10g. Citizen of Whet Country?: U.S.A.

11. Meritel Stetus: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Wes Decedent Ever in U,S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 11 Years. College (1-4or 5+): N/A

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Parts Manager

16b. Kind of Business/Industry: White Moter Company

17. Fether's Name (First, Middle, Last): Nicholas Zito

18. Mother's Neme (First, Middle, Maiden Surneme): Delaria Giovanina

19a. Informent's Neme/Reletionship (Type, Print): Yvonne Hume (Niece)

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 809 Cedar Grove Road Essex, Maryland 21221

20a. Method of Disposition: 1 [X] Buriel 2 [ ] Cremation 3 [ ] Removel from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Most Holy Redeemer Cem.

Date: 12-9-98

20c. Location - City or Town, State: Baltimore, Maryland

21. Signeture of Funeral Service Licensee: J. Wayne Osterling

22. Name and Address of Facility: Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiratory errest, shock, or heart failure. List only one ceuse on each line.

Approximete Intervel Between Onset end Deeth

Immediate Ceuse (Final disease or condition resulting in death): e. Pneumonia. — 2 Weeks

Due to (or es e consequence of):

Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury thet initieted events resulting in deeth) Lest

b. Due to (or es e consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

Myelofibrosis

Clostridium difficile colitis

23b. Did tobecco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 1 [ ] Yes 2 [ ] No

25. Wes cese referred to medical exeminer? 1 [ ] Yes 2 [X] No

26. Place of Deeth (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA. Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury et Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] **Certifying Phyeician:** To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted. 2 [ ] **Medicel Examiner:** On the basis of exemination end/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) end menner stated.

29b. Signeture end title of certifier: Attending Physician

29c. License number: D0053642

29d. Date signed (Month, Day, Yeer): Dec. 5 1998

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print): XrAo M2H04. 5601 loch Raven Blvd. Baltimore MD. 21239

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

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State Registrar

31. Date filed (Month, Day, Year): DEC 07 1998

32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37149

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Josie B. Brittingham

2. Date of Death (Month, Dey, Yeer): November 20,1998

3. Time of Death: 1433

4a. Facility Neme (If not institution, giva streat end number): PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Deeth: WICOMICO

Funeral Director

5. Social Security Number: 216-14-9309

6. Sax: 1☐ M 2☒ F

7. Aga (In yrs. last birthday): 78 Yrs.

If Undar 1 Yaar: Months / Days

If Undar 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Yeer): 12-25-1919

9. Birthplece (Stete or Foreign Country): VA.

Usuel Residenca of Decedent

10a. Stete: Md.

10b. County: Wicomico

10c. City, Town or Location: Delmar

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 300 Elizabeth St.

10f. Zip Code: 21875

10g. Citizen of Whet Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Giva Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, spacify Cuban, Mexican, Puerto Rican, atc.) 1☐ Yes 2☒ No Specify:

14. Race - Amarican Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highast grade completed): Elementery/Secondery (0-12): 2 College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work dona during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Home

17. Fether's Neme (First, Middle, Last): Thomas S. Bledsoe

18. Mother's Nema (First, Middle, Maiden Surnama): Ethel Farmer Bledsoe

19a. Informent's Name/Reletionship (Type, Print): Arlene B. Trice, Sister

19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code): 300 Elizabeth St. Delmar, Md. 21875

20a. Method of Disposition: 1☒ Buriel 2☐ Cramation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)

20b. Place of Disposition (Neme of cemetary, crametory or other piece): St. Stephens Cemetery

Dete: 11-24

20c. Location - City or Town, State: Delmar, De.

21. Signeture of Funerel Service Licensee: William M. Short

22. Name and Address of Facility: Short Funeral Home, Inc. 13 E. Grove St. Delmar, De. 19940

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on eech line.

Approximete Intervel Betwaen Onset end Death

Immediate Ceuse (Final disease or condition resulting in death)

a. ACUTE MYOCARDIAL INFARCTION — 24 HR

Due to (or es e consequence of):

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in deeth) Lest

b.

Due to (or es e consequence of):

c.

Dua to (or as a consequance of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

CHF

COPD

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Wes en eutopsy parformed? 1☐ Yes 2☒ No

24b. Were autopsy findings eveilable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To tha best of my knowledge, death occurred et the time, dete end piece, end due to the cause(s) end menner es steted. 2☐ Medical Examiner: On the basis of examination end/or investigetion, in my opinion, death occurred et the time, date end piece, end due to the cause(s) end manner stated.

29b. Signature and title of certifier: Mahesh Moondra MD

29c. Licansa number: D32014

29d. Date signed (Month, Dey, Yeer): 11/23/98

30. Name end address of person who completed cause of deeth (Item 23e) (Typa, Print): MAHESH MOONDRA 106 MILFORD ST SOYB SALISBURY MD 21801

State Registrar

31. Dete filed (Month, Dey, Yeer): NOV 23 1998

32. Registrar's Signature: Bonnie B Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "naturel', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Josie B. Brittingham 216-14-9309

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37450

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Dorothy Bernardine Combs
2. Data of Death Month Day Yaar: October 4, 1998
3. Time of Death: 3:26 AM
4a. Facility Name *(If not institution, give street and number)*: St. Mary's Nursing Center
4b. City, Town, or Location of Death: Leonardtown
4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 212-10-3277
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 91 Yrs. — If Under 1 Yaar: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: September 4, 1907
9. Birthplace *(State or Foraign Country)*: Maryland

Usual Residance of Decedant

10a. State: Maryland
10b. County: St. Mary's
10c. City, Town or Location: Leonardtown
10d. Insida City Limits: 1☐ Yas 2☒ No
10e. Street and Number: 2207 Cedar Lane Apartments
10f. Zip Coda: 20650
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Navar Marriad 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Giva Yaar or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yas 2☐ No *Specify:*
14. Race - American Indian, Black, Whita, etc. *Specify:* White

15. Decedent's Education *(Spacify only highast grada compliated)*: Elementary/Secondary (0-12): 12th; College (1-4or 5+):
16a. Dacedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa ratired)*: Clerk
16b. Kind of Business/Industry: District Court

17. Fathar's Nama *(First, Middla, Last)*: William Bernett Gardner
18. Mothar's Nama *(First, Middla, Maidan Sumama)*: Grace Gill

19a. Intormant's Name/Relationship *(Type, Print)*: Richard S. Combs/Son
19b. Mailing Address *(Street and Numbar or Rural Routa Numbar, City or Town, Stata, Zip Coda)*: 39115 Deer Lane, Mechanicsville, MD 20659

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cematary, cramatory or othar place)*: Our lady's Cemetery
Data: 10/7/98
20c. Location - City or Town, Stata: Leonardtown, MD

21. Signatura of Funaral Sarvica Licansaa: Michael Kevin Gardiner Jr.
22. Name and Address of Facility: Mattingley-Gardiner Funeral Home, P.A. P.O.Box 270, Leonardtown, MD 20650

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrest, shock, or haart tailura. List only one causa on aach lina. — Approximata Intarval Batwaan Onsat and Daath

Immediata Causa (Final disaasa or condition rasulting in death)
a. Cardio respiratory arrest
Due to (or as a consaquanca of):
b. Chronic obstructive Lung disease
Sequantially list conditions, if any, leading to immadiata causa. Entar Underlying Cause (Disaasa or Injury that Initiatad avants rasulting in daath) Last
Due to (or as a consaquanca of):
c. Diabetes mellitus
Due to (or as a consaquanca of):
d. Degenerative arthritis

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performad? 1☐ Yas 2☑ No
24b. Wara autopsy tindings available prior to completion of causa ot deeth? 1☐ Yas 2☐ No

25. Was casa rafarrad to medical examinar? 1☐ Yas 2☑ No

28. Piece of Death *(Chack only one)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA — Other: 4☑ Nursing Homa 5☐ Rasidance 6☐ Othar *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding investigation 6☐ Could not be datarmined
28a. Data of Injury *(Month, Day Year)*
28b. Tima of Injury M
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurrad
28e. Place of Injury - At home, tarm, street, factory, office building, atc. *(Spacify)*
28f. Location *(Street and Numbar or Rural Routa Numbar, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To tha best of my knowladga, daath occurrad at tha time, data and placa, and dua to tha causa(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of axamination and/or invastigation, in my opinion, death occurrad at the time, date and place, and dua to tha cause(s) and manner stated.

29b. Signatura and titla of cartifiar:
29c. Licansa number: D09178
29d. Data signad *(Month, Day, Year)*: 10-5-1998

30. Nama and address of person who compliated causa of death (Item 23a) (Type, Print): Youngsik Moon, MD Hollywood, MD 20636

State Registrar

31. Data filad *(Month, Day, Year)*: OCT 06 1998
32. Registrar's Signatura: Geneva G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37451

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lillian Susan Cathell
2. Date of Death: Month November Day 18 Year 1998
3. Time of Death: 1410
4a. Facility Name (If not institution, give street end number): PENINSULA REGIONAL MEDICAL CENTER
4b. City, Town, or Location of Death: SALISBURY
4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 226-36-5266
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Year): Jan. 7, 1913
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Virginia
10b. County: Accomack
10c. City, Town or Location: Chincoteague
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3550 Willow Stree et
10f. Zip Code: 23336
10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed): Elementary/Secondary (0-12): 7 College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Self

17. Father's Name (First, Middle, Last): Jacob John Krak
18. Mother's Name (First, Middle, Maiden Sumeme): Maria Mary Zelonka

19a. Interment's Name/Relationship (Type, Print): Susan Watson Granddaughter
19b. Mailing Address (Street end Number or Rurel Route Numbar, City or Town, Stete, Zip Code): 220 Barnes Road, Pocomoke, Maryland 21851
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, crematory or other place): John Taylor Cemetery Date: 11-22-98
20c. Location - City or Town, State: Temperanceville, Va.
21. Signature of Funeral Service Licensee: Constance Salyer Cordrey Bailey
22. Name and Address of Facility: Salyer Funeral Home Chincoteague, Virginia 23336

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart tailure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in deeth)
e. Refractory Cardiac Arrhythmia

Due to (or as a consequence of):
b. Congestive Cardiomyopathy & CHF 3yr

Sequentially list conditions, if any, leading to immediate ceuse. Entar Underlying Ceusa (Disease or injury that initiated evants resulting in deeth) Last
Due to (or as e consequence of):
c. CAD & myocardial ischemia 3yr

Due to (or es e consequence of):
d.

Part II. **Other significant conditione** contributing to death but not resulting in the underlying cause givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yas 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of ceuse ot death? 1☐ Yes 2☐ No

25. Was cese referred to medical examiner? 1☐ Yes 2☒ No
26. Piece of Death (Chack only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Panding investigation 6☐ Could not be determined
28a. Data of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28t. Location (Street end Number or Rurel Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceusa(s) and mannar es steted. 2☐ Medical Examiner: On the basis of examination end/or investigetion, in my opinion, death occurred at the time, date end piece, and due to the ceuse(s) and manner es steted.
29b. Signature and title of certifier:
29c. License number: D20441
29d. Date signed (Month, Dey, Year): November 18, 1998
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph Raffetto MD 400 Eastern Shore Dr., Salisbury MD 21804

State Registrar

31. Deta filed (Month, Day, Year): NOV 23 1998
32. Registrar's Signature: Geneva G Sparks

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

226 - 36 - 5266

Lillian S. Cathell

12

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37452

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EUNICE H. CATHELL

2. Date of Death Month/Day/Year: NOVEMBER 19 1998

3. Time of Death: 9:00 PM

4a. Facility Name (If not institution, give street and number): 11310 CATHAGE ROAD

4b. City, Town, or Location of Death: BERLIN

4c. County of Death: WORCESTER

Funeral Director

5. Social Security Number: 215-16-3364

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): DEC. 10, 1919

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: WORCESTER

10c. City, Town or Location: BERLIN

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 11310 CATHAGE ROAD

10f. Zip Code: 21811

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SEAMSTRESS

16b. Kind of Business/Industry: CLOTHING

17. Father's Name (First, Middle, Last): ALBERT S. DONAWAY

18. Mother's Name (First, Middle, Maiden Surname): SARAH G. POWELL

19a. Informant's Name/Relationship (Type, Print): LEVI T. CATHELL/HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11310 CATHAGE ROAD, BERLIN, MARYLAND 21811

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): DALE CEMETERY

Date: 11/23/98

20c. Location - City or Town, State: WHALEYVILLE, MARYLAND

21. Signature of Funeral Service Licensee: Charles W Hastings

22. Name and Address of Facility: HASTINGS FUNERAL HOME, SELBYVILLE, DELAWARE 19975

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Chronic obstructive pulmonary disease — 10 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Physician

29c. License number: H44283

29d. Date signed (Month, Day, Year): 11/20/98

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Robert Durkin 9733 Healthway Drive Berlin, MD

State Registrar

31. Date filed (Month, Day, Year): NOV 20 1998

32. Registrar's Signature: Donna G Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37453

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Lola Helen Carnes
2. Date of Death Month Day Year: September 30, 1998
3. Time of Death: 1305
4a. Facility Name *(If not institution, give street end number)*: Bayside Care Center
4b. City, Town, or Location of Death: Lexington Park
4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 212-07-2581
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 94 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: September 28, 1904
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10e. State: Maryland
10b. County: St. Mary's
10c. City, Town or Location: Drayden
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 46781 Edwards Lane
10f. Zip Code: 20630
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8th; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: George Marshall Edwards
18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Helen Hewitt

19a. Informant's Name/Relationship *(Type, Print)*: Mary Jane Shorter/Niece
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8607 Drumwood Road, Baltimore, MD 21286

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: St. George's Episcopal Cemetery
Date: 10/3/98
20c. Location - City or Town, State: Valley Lee, MD

21. Signature of Funeral Service Licensee: Michael K. Gardiner
22. Name and Address of Facility: Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Atherosclerotic Cardiovascular disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D14285
29d. Date signed *(Month, Day, Year)*: 10-1-98

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): William Boyd, II MD Leonardtown, MD 20650

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 02 1998
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37454

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month / Dey / Year	3. Time of Death
Arthur	Davis	October 1, 1998	11:40 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
St. Mary's Nursing Center	Leonardtown	St. Mary's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Deys	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Dey, Yeer)	9. Birthplace (State or Foreign Country)
408-26-2062	1☒ M 2☐ F	90 Yrs.			December 29,1907	Tennessee

Usual Residence of Decedent

10a. Stete	10b. County	10c. City, Town or Location	10d. Inside City Limits
Tennessee	Madison	Jackson	1☐ Yes 2☒ No

10e. Street end Number	10f. Zip Code	10g. Citizen of Whet Country?
51 Lakewood Drive	38305	U.S.A.

11. Marital Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.)	14. Rece - American Indien, Bleck, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Yeer or Dates:	1☐ Yes 2☒ No *Specify:*	*Specify:* White

15. Decedent's Education (Specify only highest grade completed)		16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8th		Painter	Painter

17. Fether's Neme (First, Middle, Lest)	18. Mother's Name (First, Middle, Meiden Surneme)
Robert J. Davis	Violet Mae Davis

19e. Informent's Name/Relationship (Type, Print)	19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)
Shirley Davis/Daughter-in-law	51 Lakewood Drive, Jackson, TN 38305

20e. Method of Disposition	20b. Piece of Disposition (Neme of cemetery, cremetory or other piece)	Date	20c. Location - City or Town, Stete
1☒ Buriel 2☐ Cremetion 3☐ Removel from Stete 4☐ Donation 5☐ Other (Specify)	Highland Memorial Gardens	10/5/98	Jackson, Tennessee

21. Signature of Funeral Service Licensee	22. Name end Address of Facility
▶ Michael K. Gardiner	Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximete Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cardiopulmonary Failure	minutes
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that inltieted events resulting in deeth) Lest	b. Due to (or as a consequence of): Aspiration Pneumonia	hrs.
	c. Due to (or as a consequence of): Dysphagia	months
	d. Due to (or as a consequence of): Cerebrovascular Insufficiency	yrs.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown	1☐ Yes 2☒ No	1☐ Yes 2☐ No N/A

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Deeth	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one)

1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) end manner es steted.

2☐ **Medical Exeminer.** On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Yeer)
▶ J. Patrick Jarboe M.D.	D 06449	10-1-98

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

J. Patrick Jarboe, MD Hollywood, MD 20636

State Registrar

31. Dete filed (Month, Day, Year)	32. Registrer's Signature
OCT 0 2 1998	Geneva G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Vida Dixon
767-6483

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98-37455

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)				2. Date of Death Month / Day / Year	3. Time of Death
JOHN	ROBERT	FARRELL	SR	November 19, 1998	7:05 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
402 Valleywood Drive	Salisbury	Wicomico

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-12-5188	1☒ M 2☐ F	75 Yrs.			February 3, 1923	Pennsylvania

Usual Residance of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Wicomico	Salisbury	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
402 Valleywood Drive	21804	USA

11. Maritel Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.)	14. Race - American Indien, Bleck, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☒ Yes 2☐ No If Yes, Give Yeer or Dates: Navy WW II	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grede completad)		16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elamantary/Secondary (0-12)	Collega (1-4or 5+)		
12	-	Exterminator	Exterminating

17. Father's Name (First, Middle, Lest)	18. Mother's Nema (First, Middle, Maiden Surneme)
Roy Crawford Farrell	Mary Florence Shockley

19a. Informant's Name/Reletionship (Type, Print)	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)
Mary F. Farrell/Spouse	402 Valleywood Dr., Salisbury, MD 21804

20e. Method of Disposition	20b. Placa of Disposition (Neme of cemetery, cremetory or other piece)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Wicomico Memorial Park	11/23/98	Salisbury, MD

21. Signeture of Funeral Servica Licansee	22. Neme end Address of Fecility
David A. Compson	Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only ona cause on aach line.

		Approximete Interval Between Onset and Death
Immediate Ceuse (Final disease or condition resulting in death)	e. Malignant Lymphoma	
	Due to (or as a consequence of):	
Sequentially list conditions, if eny, leading to immediate causa. Enter Underlying Ceuse (Diseese or injury thet initieted events rasulting in daeth) Last	b.	
	Due to (or es e consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditiona** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Piece of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☒ Residenca 6☐ Other (Specify)

27. Manner of Death	28a. Dete of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be datarmined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At homa, farm, straat, fectory, offica building, etc. (Spacify)			28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one) 1☒ **Certifying Phyeician:** To the best of my knowladga, daath occurred at tha tima, date end placa, and dua to tha causa(s) and mannar as statad.
2☐ **Medicat Examiner:** On the basis of examination end/or investigation, in my opinion, deeth occurred et tha time, date end place, end due to the ceuse(s) end manner stated.

29b. Signature end title of certifier	29c. Licanse number	29d. Date signed (Month, Day, Year)
MD	D20507	11/19/98

30. Name end address of person who completed cause of death (Item 23a) (Type, Print): Joseph A Grasso MD 145 E Carroll St Salisbury MD 21801

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 20 1998	G Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37456

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Maude Ellen Helms

2. Data of Deeth: Month October Day 11 Year 1998

3. Tima of Death: 5:20 PM

4a. Facility Nama (If not institution, giva straat and number): St. Mary's Hospital

4b. City, Town, or Location of Death: Leonardtown

4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 216-74-1145

6. Sex: 1☐ M 2☒ F

7. Aga (In yrs. last birthday): 88 Yrs.

If Under 1 Yaar: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Dey, Yaar): February 8, 1910

9. Birthplaca (Stata or Foraign Country): Virginia

Usual Residenca of Decedant

10a. Stata: Maryland

10b. County: St. Mary's

10c. City, Town or Location: Hollywood

10d. Insida City Limits: 1☐ Yas 2☒ No

10e. Street end Number: 25624 Three Notch Road

10f. Zip Coda: 20636

10g. Citizan of What Country?: U.S.A.

11. Marital Status: 1☐ Navar Marriad 2☐ Marriad 3☒ Widowed 4☐ Divorcad

12. Was Dacedant Evar in U,S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, atc. Specify: White

15. Decedent's Education (Specify only highest grada completad): Elementary/Secondary (0-12): 9th; College (1-4or 5+):

16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT usa ratired): Homemaker

16b. Kind of Businass/Industry: Own Home

17. Father's Nama (First, Middla, Last): Homer Atkin Alderman

18. Mothar's Name (First, Middla, Maidan Sumame): Litha Slusher

19a. Informant's Name/Ralationship (Type, Print): Homer Helms/Son

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Steta, Zip Code): 26260 Clarks Village Lane, Mechanicsville, MD 20659

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from Stata 4☐ Donation 5☐ Othar (Specify)

20b. Place of Disposition (Name of camafary, cramatory or othar placa): Mt. Zion Un.Methodist Cemetery

Data: 10/15/98

20c. Location - City or Town, State: Mechanicsville, MD

21. Signatura of Funaral Sarvice Licansea: Michael K. Gardiner

22. Nama and Address of Facility: Mattingley-Gardiner Funeral Home, P.A. P.O.Box 270, Leonardtown, MD 20650

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complications that causad tha daath. Do not enter tha moda of dying, such es cardiac or raspiratory errest, shock, or haart failura. List only ona causa on aach lina.

Approximate Intarval Batween Onset end Death

Immediata Causa (Final disaasa or condition resulting in death)

a. Acute respiratory failure — about one week

Dua to (or as a consequenca of):

Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Cause (Disaasa or injury that initiatad avants rasulting in daath) Last

b. Congestive heart failure

Dua to (or as a consaquance of):

c. Chronic renal failure

Dua to (or as a consequance of):

d.

Part II. **Othar significant conditions** contributing to death but not rasulting in tha underlying cause given in Part I.: pleural effusion

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performad? 1☐ Yas 2☑ No

24b. Were autopsy findings aveilable prior to complation of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examinar? 1☐ Yas 2☑ No

26. Ptece of Death (Check only one): Hospital: 1☑ Inpatiant 2☐ ER/Outpetient 3☐ DOA; Othar: 4☐ Nursing Homa 5☐ Rasidance 6☐ Othar (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding Invastigation 6☐ Could not be datarminad

28a. Data of Injury (Month, Day Yaar)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At homa, farm, straat, factory, offica building, etc. (Specify)

28f. Location (Straat and Number or Rural Routa Numbar, City or Town, Stata)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at tha tima, data and place, and dua to the cause(s) and mannar es stated. 2☐ **Medical Examiner**: On tha basis of examination and/or investigation, in my opinion, death occurrad at tha tima, data and place, end due to tha cause(s) and manner stated.

29b. Signature end title of certifier: (DR.M.A. Rahman,MD)

29c. Licanse number: D50044

29d. Date signed (Month, Day, Yaar): 10/12/1998

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print): MOHAMMAD A.RAHMAN M.D. PHILIP J.BEAN MEDICAL CTR.HOLLYWOOD,MD. 20636

State Registrar

31. Data filad (Month, Day, Yaar): OCT 13 1998

32. Registrar's Signature: Sandra G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

MAUDE E. HELMS

To the Hospital or Attending Physician: The law requiras that the death certificate be executed within 24 hours aftar death.
To the Funaral Director: After this certificate has been signed by the attanding physician and completaly filled in by the funaral diractor, page 2 should be datached for use es the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98-37457

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Data of Death Month / Day / Year	3. Tima of Death
Thomas	Collaton	Hubric	Nov. 19, 1998	10:45 PM

4a. Facility Nama (If not institution, giva street and number)	4b. City, Town, or Location of Death	4c. County of Death
Salisbury Center; Genesis ElderCare	Salisbury, Md	Wicomico

Funeral Director

5. Social Security Number	6. Sax	7. Aga (In yrs. last birthday)	If Under 1 Year: Months / Deys	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
134-01-6306	1☒ M 2☐ F	81 Yrs.			12/28/1916	N.Y. State

Usual Residence of Decedant

10a. Stata	10b. County	10c. City, Town or Location	10d. Inside City Limits
N.Y.	Erie	Williamsville , N.Y.	1☒ Yas 2☐ No

10e. Street and Number	10f. Zip Coda	10g. Citizen of What Country?
8679 Sunset Drive	14221	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forcas?	13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puerto Rican, etc.)	14. Race - American Indian, Black, Whita, atc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☒ Yas 2☐ No If Yas, Giva Year or Datas: WW2	1☐ Yas 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highast grada completed)		16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use ratired)	16b. Kind of Businass/Industry
Elementery/Secondery (0-12)	Collega (1-4or 5+)		
11		Claims Supervisor	Insurance Industry

17. Father's Nama (First, Middle, Last)	18. Mothar's Nama (First, Middle, Maiden Surname)
William Hubric	Clara Collation

19a. Informant's Name/Ralationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda)
Thomas Hubric	20108 Nanticoke Rd.,Nanticoke, Md.21840

20a. Mathod of Disposition	20b. Place of Disposition (Nama of cemetary, cramatory or othar place)	Data	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Othar (Specify)	Salisbury Crematory	11/21	Salisbury, Md.

21. Signeture of Funaral Sarvice Licensaa	22. Nama and Address of Facility
Cornelius Messick M00-417 Cornelius Messick	Messick Funeral Home, P.O. Box 61 Bivalve, Maryland 21814

Physician /Medical Examiner

23a. Part1. Enter tha disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on aach lina.

		Approximata Intarvat Batween Onset and Death
Immediata Causa (Final disaasa or condition resulting in death)	a. Pneumonia	days
Due to (or as a consequance of):	b. Parkinson's disease	yrs.
Sequantially list conditions, if any, laading to immediata cause. Enter Undarlying Cause (Disease or injury that initiated evants rasulting in death) Last	c. Dementia	yrs.
Due to (or as e consaquence of):	d.	

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to complation of cause of death?
1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown	1☐ Yes 2☑ No	1☐ Yes 2☐ No

25. Was casa rafarrad to medical examinar?	26. Placa of Death (Check only one)	
1☐ Yas 2☑ No	Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA	Other: 4☑ Nursing Hama 5☐ Rasidence 6☐ Othar (Specify)

27. Mannar of Death	28a. Date of Injury (Month, Day Year)	28b. Tima of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be datarmined		M	1☐ Yas 2☐ No	

28a. Placa of Injury - At home, farm, street, factory, office building, atc. (Specify)	28f. Location (Street and Number or Rural Routa Number, City or Town, State)

29a. Cartifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred at tha time, dete and place, end dua to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, deeth occurred at the tima, date and place, and due to tha ceuse(s) and mannar stated.

29b. Signature and title of certifier	29c. Licensa number	29d. Data signed (Month, Day, Year)
	029349	11/20/98

30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print)

Williams Robins, M.D 1104 HEALTHWAY Dr.,Salisbury, Md. 21804

State Registrar

31. Data filed (Month, Day, Year)	32. Registrar's Signatura
NOV 23 1998	Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with tha Maryland Department of Haalth and Mental Hygiena.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requiras that tha death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by tha attanding physician and completaly filled in by tha funeral director, page 2 should be detached for usa as the burial-transit.

Medical Certification: To Be Completed by Physician/Medical Examiner

NOV 5 3 1988

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Sallie J. Hill
2. Dete of Deeth: Month 01 Dey 09 Year 98
3. Time of Death: 11:20 am
4a. Facility Name (If not institution, give street end number): Atlantic General Hospital
4b. City, Town, or Location of Deeth: Berlin
4c. County of Deeth: Worcester

Funeral Director

5. Social Security Number: 195-10-1028
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 93 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Yeer): Sept. 17, 1906
9. Birthplace (State or Foreign Country): VA

Usual Residence of Decedent

10a. Stete: MD
10b. County: Worces6ter
10c. City, Town or Location: Snow Hill
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street end Number: 416 Covington St.
10f. Zip Code: 21863
10g. Citizen of Whet Country?: U.S.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - Americen Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grede completed): Elementary/Secondary (0-12): 7th | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Attendant
16b. Kind of Business/Industry: Nursing Home

17. Fether's Name (First, Middle, Lest): James Barkley
18. Mother's Name (First, Middle, Maiden Surneme): Jennie Johnson

19a. Informent's Name/Relationship (Type, Print): Viola Wilson/sister
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 416 Covington St., Snow Hill, MD 21863

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Mt. Zion Baptist Church
Date: 11/24/98
20c. Location - City or Town, State: Snow Hill, MD

21. Signature of Funeral Service Licensee: [signature]
22. Neme end Address of Facility: Lewis N. Watson Funeral Home, 1618 West Rd., Salisbury, MD 21801

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one ceuse on eech line.

Approximete Interval Between Onset end Death

Immediate Ceuse (Finel diseese or condition resulting in deeth)
a. resp. failure
Due to (or as a consequence of):
b. Sepsis
Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Lest
Due to (or as a consequence of):
c. B/L asp. Pneumonia
Due to (or as a consequence of):
d. CVA's in Past

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Hx CVA's Past
DM, insulin Req. type II

23b. Did tobecco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1☐ Yes 2☐ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Plece of Deeth (Check only one): Hospital: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Yeer)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☐ Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end menner es steted. 2☐ Medical Examiner: On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, date and place, end due to the ceuse(s) and manner stated.
29b. Signature and title of certifier: [signature], M.D.
29c. License number: D-0048221
29d. Date signed (Month, Day, Year): 11/14/98
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Julie M. DeSean, MD, AGH.

State Registrar

31. Dete filed (Month, Day, Yeer): NOV 23 1998
32. Registrar's Signature: Geneva G Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Audrey B. Killmon
2. Date of Death Month Day Yeer: Nov. 18, 1998
3. Time of Deeth: 9:45AM
4e. Facility Name (If not institution, give street end number): 108 Spruce Street
4b. City, Town, or Location of Death: Delmar
4c. County of Deeth: Wicomico

Funeral Director

5. Social Security Number: 227-24-1244
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 72 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Yeer): Feb. 24, 1926
9. Birthplece (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: MD
10b. County: Wicomico
10c. City, Town or Localion: Delmar
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street end Number: 108 Spruce Street
10f. Zip Code: 21875
10g. Citizen of Whet Country?: U.S.A.

11. Marital Slalus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedenl Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dales:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 4
16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Registered Nurse
16b. Kind of Business/Industry: Hospital

17. Fether's Neme (First, Middle, Last): Weldon Berry
18. Mother's Name (First, Middle, Maiden Surname): Mary Walker Berry

19e. Informent's Name/Relationship (Type, Print): Marilyn Searcey/Granddaughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 11 Spruce Street Delmar, MD 21875

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, crematory or other place): St. Stephens Cemetery
Date: 11-21
20c. Location - City or Town, State: Delmar, Delaware

21. Signalure of Funeral Service Licensee: Holly Hannigan
22. Name and Address of Facility: Short Funeral Home 13 E. Grove Street Delmar, DE 19940

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the dealh. Do nol enter the mode of dying, such es cardiac or respiretory errest, shock, or heert failure. List only one cause on each line. Approximete Interval Between Onset end Death

Immediate Ceuse (Final disease or condition resulting in death): e. Ruptured Aortic Aneurysm.
Due to (or es e consequence of): ASCVD
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in deeth) Last:
b. Due to (or es e consequence of):
c. Due to (or es a consequence of):
d.

Part II. **Other significant conditions** conlributing lo dealh but nol resulting in the underlying ceuse given in Part I.: GERD; Hiatal hernia

23b. Did tobecco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was en eutopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical exeminer? 1☐ Yes 2☒ No
26. Piece of Death (Check only one): Hospital: 1☐ Inpetient 2☐ ER/Oulpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)
27. Menner of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28e. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Phyeician:** To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end manner es steted. 2☐ **Medical Exeminer:** On the basis of examination and/or Investigation, In my opinion, deeth occurred et the time, date end piece, end due to the ceuse(s) end manner stated.

29b. Signeture end title of certifier: [signature]
29c. License number: D29105
29d. Dale signed (Month, Dey, Yeer): 11/20/98

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print): C.J. Huddleston, M.D 106 Milford St Suite 103 Salisbury MD

State Registrar

31. Dete filed (Month, Dey, Yeer): NOV 20 1998
32. Registrer's Signeture: Geneva G Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

8

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37460

Physician /Medical Examiner

1. Decedent's Nama (First, Middle, Last)	2. Data of Daath Month Day Yaer	3. Tima of Death
Charles Wyte Mullins	October 11, 1998	5:30 PM

4a Facility Nama (If not institution, giva street and number)	4b. City, Town, or Location of Deeth	4c. County of Death
45194 Nats Creek Road	Hollywood	St. Mary's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months / Days	If Under 24 Hrs. Hours / Min.	8. Data of Birth (Month, Day, Yaar)	9. Birthplace (State or Foraign Country)
216-50-7327	1☒M 2☐F	49 Yrs.			February 18, 1949	West Virginia

Usual Rasidanca of Decedant

10a. Stete	10b. County	10c. City, Town or Location	10d. Insida City Limits
Maryland	St. Mary's	Hollywood	1☐Yas 2☒No

10e. Street and Number	10f. Zip Coda	10g. Citizan of What Country?
45194 Nats Creek Road	20636	U.S.A.

11. Marital Status	12. Was Decedant Ever in U.S. Armed Forcas?	13. Was Decedant of Hispanic Origin? (Specify Yas or No- if Yas, specify Cuban, Maxican, Puarto Rican, atc.)	14. Raca - Amarican Indian, Black, Whita, atc.
1☐Navar Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yas, Giva Yeer or Datas:	1☐Yas 2☒No Specify:	Specify: White

15. Decedant's Education (Specify only highast grada complatad)		16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired)	16b. Kind of Businass/Industry
Elementery/Secondery (0-12)	College (1-4or 5+)		
7th		Assistant Manager	Retail Store

17. Fathar's Nama (First, Middla, Last)	18. Mothar's Nema (First, Middla, Maidan Sumama)
Oral Dow Wyte Fay Mullins	Maxine Taylor

19a. Informant's Name/Ralationship (Typa, Print)	19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda)
Joan Mullins/Spouse	45194 Nats Creek Road, Hollywood, MD 20636

20a. Mathod of Disposition	20b. Placa of Disposition (Nama of cematary, cramatory or othar placa)	Date	20c. Location - City or Town, Stata
1☒Burial 2☐Cramation 3☐Ramoval from Stata 4☐Donation 5☐Other (Specify)	Charles Memorial Gardens	10/14/98	Leonardtown, Maryland

21. Signatura of Funeral Service Licensee	22. Nama and Address of Facility
Michael K. Gardiner	Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arast, shock, or heart failure. List only one cause on each line.

		Approximata Intarval Batween Onsat and Daath
Immediata Causa (Finel disaasa or condition resulting in death)	a. Metastatic Small Cell Carcinoma of the Lung	12/97
Sequantially list conditions, if any, laading to immadiate causa. Entar Underlying Cause (Disaasa or injury that initieted avents rasulting in death) Last	b. Due to (or as a consequanca of):	
	c. Due to (or as a consequance of):	
	d.	

Part II. **Othar significant conditions** contributing to death but not resulting in the underlying causa givan in Part I.

23b. Did tobacco use contributa to the cauae of death?	24a. Wes an autopsy performed?	24b. Were autopsy findings availabla prior to complation of causa of death?
1☐Yes 2☐No 3☑Probably 4☐Unknown	1☐Yas 2☒No	1☐Yas 2☐No

25. Was case refarred to medical examinar?	26. Placa of Death (Check only ona)	
1☐Yas 2☒No	Hospital: 1☐Inpatiant 2☐ER/Outpatient 3☐DOA	Othar: 4☐Nursing Homa 5☒Rasidance 6☐Othar (Specify)

27. Mannar of Daath	28a. Data of Injury (Month, Day Yaar)	28b. Tima of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Naturel 2☐Accidant 3☐Sulcida 4☐Homicida 5☐Panding investigation 6☐Could not be datarmined		M	1☐Yes 2☐No	
	28a. Placa of Injury - At home, farm, straat, factory, office building, atc. (Specify)			28f. Location (Straat and Number or Rural Route Number, City or Town, Stata)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Cartifiar (Check only one) 1☒**Certifying Physician:** To tha best of my knowledge, death occurred at tha tima, data and place, and due to tha causa(s) and mennar es steted. 2☐**Medical Examinar:** On the basis of axamination and/or investigation, in my opinion, daath occurred at tha tima, data and placa, and dua to tha cause(s) and mannar stated.

29b. Signatura and title of certifier	29c. Licensa number	29d. Date signed (Month, Day, Year)
Michael S. Szkotnicki, MD	D31952	10/13/98

30. Nama and addrass of person who completed causa of death (Item 23e) (Type, Print)
22576 MacArthur BIRD, SanSouci Plaza California, MD 20619

State Registrar

31. Date filad (Month, Day, Yaar)	32. Registrar's Signatura
OCT 13 1998	Brenda G. Sparks

To the Hospital or Attending Physician: The law requiras that tha daath certificate be executed within 24 hours after daath.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, paga 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Haalth and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Amend #26 WCHD 11/20/98 cle

Reg. No. 90 37461

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last)			2. Dete of Death Month	Dey	Year	3. Time of Deeth
Flora	Purnell		Nov	18	1998	1:00 Am

4a Fecility Neme (If not institution, give street end number)	4b. City, Town, or Location of Deeth	4c. County of Deeth
400-C Trinity Dr.	Salisbury	Wicomico

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. lest birthdey)	If Under 1 Year Months	Deys	If Under 24 Hrs. Hours	Min.	8. Date of Birth (Month, Day, Yeer)	9. Birthplece (State or Foreign Country)
218-20-2830	1☐ M 2☒ F	71 Yrs.					Nov. 8, 1927	GA

Usual Residenca of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Wicomico	Salisbury	1☐ Yes 2☐ No

10e. Street end Number	10f. Zip Code	10g. Citizen of Whet Country?
400-C Trinity Dr.	21801	U.S.

11. Maritel Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.)	14. Race - Americen Indien, Bleck, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grede completed)		16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11th		Laborer	Laundry

17. Father's Neme (First, Middle, Last)	18. Mother's Name (First, Middle, Meiden Surneme)
Rochelle Ray	Mazie Green

19a. Informent's Neme/Reletionship (Type, Print)	19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code)
James Purnell, Jr./son	1202 Gannet Ave., Salisbury, MD 21801

20a. Method of Disposition	20b. Piece of Disposition (Neme of cemetery, crematory or other piece)	Dete	20c. Location - City or Town, Stete
1☑ Buriel 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)	Green Acres Mem Park	11/21/98	Salisbury, MD

21. Signature of Funeral Service Licensee	22. Name end Address of Fecility
▶ [signature]	Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD 21801

Physician /Medical Examiner

23e. Part I. Enter the diseese, or complicetions thet ceused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert failure. List only one cause on each line.

		Approximate Interval Between Onset end Death
Immediate Cause (Final disease or condition resulting in death)	a. ATHEROSCLEROTIC CARDIO VASCULAR.	
Due to (or es e consequence of):	DISEASE &	
Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in death) Lest	b. SUDDEN CARDIAC death	< 24 HR.
Due to (or es e consequence of):	c.	
Due to (or es e consequence of):	d.	

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION.

GOITRE

23b. Did tobacco uee contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24e. Wes en eutopsy performed?	24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth?
1☐ Yes 2☐ No	1☐ Yes 2☐ No

25. Wes case referred to medical exeminer?	26. Plece of Death (Check only one)	
1☐ Yes 2☑ No	Hospital: 1☐ Inpetient 2☑ ER/Outpetient 3☐ DOA	Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Dete of Injury (Month, Dey Yeer)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one) 1☑ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end placa, end due to the cause(s) end menner as stated. 2☐ **Medical Examiner:** On the besis of exemination end/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) end menner stated.

29b. Signature end title of certifier	29c. License number	29d. Date signed (Month, Dey, Yeer)
▶ [signature] MD	D32014	11/20/98

30. Neme end eddress of person who completed ceuse of deeth (Item 23a) (Type, Print)

MAHESH MOONDRA 106 MILFORD ST. SOUTH SALISBURY MD 21804

State Registrar

31. Date filed (Month, Dey, Yeer)	32. Registrer's Signature
NOV 20 1998	[signature] G Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37462

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): George Edmond Russell
2. Date of Death: Month October Day 10 Year 1998
3. Time of Death: 6:20 PM
4a. Facility Name (If not institution, give street and number): St. Mary"s Hospital
4b. City, Town, or Location of Death: Leonardtown
4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 220-26-6834
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 75 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): October 12,1922
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: St. Mary's
10c. City, Town or Location: Leonardtown
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 25565 Point Lookout Road
10f. Zip Code: 20650
10g. Citizen of What Country?: USA

11. Maritel Stetus: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12th; College (1-4or 5+):
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Farmer
16b. Kind of Business/Industry: Farm

17. Fether's Name (First, Middle, Last): George Clayton Russell
18. Mother's Name (First, Middle, Maiden Sumeme): Rose Alice Suite

19a. Informant's Name/Reletionship (Type, Print): Cora V. Norris/Sister
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): P.O.Box 432, Leonardtown, Md 20650

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other piece): Charles Memorial Gardens
Dete: 10/14/98
20c. Location - City or Town, Stete: Leonardtown, Md

21. Signature of Funeral Service Licensee: Michael R Gardiner
22. Name and Address of Facility: Mattingley-Gardiner Funeral Home, P.A. P.O.Box 270, Leonardtown, Md 20650

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Chronic Obstructive Pulmonary Disease	About 10 yrs
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last b.		
Due to (or as e consequence of):		
c.		
Due to (or as e consequence of):		
d.		

Part II. **Other eignificant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.: Organic Brain Syndrome; Seizure Disorder

23b. Did tobacco use contributa to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24e. Wes an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was cese referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Menner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner as stated. 2 [ ] **Medical Examiner**: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: (DR.m.A. Rchman, MD)
29c. License number: D50044
29d. Date signed (Month, Day, Year): 10/12/98

30. Name end address of person who completed cause of death (item 23a) (Type, Print): Mohammed Rahman M.D. Philip J. Bean Medical Ctr. Hollywood, Md 20636

State Registrar

31. Date filed (Month, Day, Year): OCT 13 1998
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, pege 2 should be detached for use es the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: REBECCA PERRY REID
2. Data of Death Month / Day / Year: NOVEMBER 24, 1998
3. Time of Death: 6:00AM
4a. Facility Name *(If not institution, give street and number)*: DORCHESTER GENERAL HOSPITAL
4b. City, Town, or Location of Death: CAMBRIDGE
4c. County of Death: DORCHESTER

Funeral Director

5. Social Security Number: 213-14-8318
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 76 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: JULY 24, 1922
9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: DORCHESTER
10c. City, Town or Location: HURLOCK
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 410 CHARLES STREET
10f. Zip Code: 21643
10g. Citizen of What Country?: USA
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: BUS DRIVER
16b. Kind of Business/Industry: COUNTY SCHOOL SYSTEM
17. Father's Name *(First, Middle, Last)*: EMMETT CHARLES PERRY
18. Mother's Name *(First, Middle, Maiden Surname)*: EVA CHAMBERS
19a. Informant's Name/Relationship *(Type, Print)*: BARBARA KILLOUGH/DAUGHTER
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: P. O. BOX 3, HURLOCK, MARYLAND 21643
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: UNITY WASHINGTON CEMETERY
Date: 11/27
20c. Location - City or Town, State: HURLOCK, MARYLAND
21. Signature of Funeral Service Licensee: Ronald Zeller
22. Name and Address of Facility: ZELLER FUNERAL HOME, P. O. BOX 207, 106 MAIN STREET, EAST NEW MARKET, MD 21631

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	End Stage Renal Disease	2 mo
Due to (or as a consequence of): b.	Vascular Insufficiency	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Severe COPD

23b. **Did tobacco use contribute to the cause of death?** 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Data of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: C1000167 5
29d. Date signed *(Month, Day, Year)*: 11/24/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARK J. GRANADA, M.D., 1720 MIDDLEFORD ROAD, SEAFORD, DE 19973

State Registrar

31. Data filed *(Month, Day, Year)*: NOV 25 1998
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

98-5904-037
crn
James Phillip Senn

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37464

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Dey Yeer	3. Time of Death
James Philip Senn	October 07, 1998	4:01 P.M.

4a Facility Name (If not institution, give street end number)	4b. City, Town, or Location of Death	4c. County of Death
St. Mary's Hospital	Leonardtown	St. Mary's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months / Days	If Under 24 Hrs. Hours / Min.	8. Date of Birth (Month, Dey, Yeer)	9. Birthplece (State or Foreign Country)
393-32-2199	1■ M 2☐ F	63 Yrs.			December 11,1934	Wisconsin

Usuel Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	St. Mary's	Hollywood	1☐ Yes 2■ No

10e. Street and Number	10f. Zip Code	10g. Citizen of Whet Country?
26111 Captains Point Lane	20636	United States

11. Meritel Stetus	12. Was Decedent Ever in U.S. Armed Forces?	13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indien, Bleck, White, etc.
1☐ Never Married 2■ Married 3☐ Widowed 4☐ Divorced	1■ Yes 2☐ No If Yes, Give Yeer or Dates 1965-1992	1☐ Yes 2■ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondery (0-12)	College (1-4or 5+)		
	8	Commissioned Officer/Med.Corps	U.S. Navy

17. Fether's Neme (First, Middle, Last)	18. Mother's Neme (First, Middle, Maiden Surneme)
Henry Senn	Catharine Vach

19e. Informent's Name/Reletionship (Type, Print)	19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code)
Marilyn Senn, Wife	26111 Captains Point Lane, Hollywood, MD 20636

20a. Method of Disposition	20b. Plece of Disposition (Neme of cemetery, cremetory or other place)	Dete	20c. Location - City or Town, Stete
1■ Buriel 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)	St. John's Cemetery	10-12-98	Hollywood, Maryland

21. Signature - Funeral Service Licensee	22. Neme end Address of Fecility
Edward N. Brinsfield,Jr. M00052	Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 20650

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mentel Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert failure. List only one ceuse on each line.

Approximate Interval Between Onset end Death

Immediate Ceuse (Final disease or condition resulting in death)
e. Atherosclerotic Cardiovascular Disease

Due to (or es e consequenca of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest
b.
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?
1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Was en eutopsy performed?	24b. Were eutopsy findings aveilable prior to completion of cause of deeth?
1☒ Yes 2☐ No	1☒ Yes 2☐ No

25. Was case referred to medical examiner?	26. Plece of Deeth (Check only one)	
1☒ Yes 2☐ No	Hospitel: 1☐ Inpetient 2☒ ER/Outpetient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth	28a. Dete of Injury (Month, Dey Yeer)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)			28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The lew requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificete hes been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner es steted.
2☒ **Medical Examiner:** On the besis of examination end/or investigetion, in my opinion, deeth occurred et the time, dete end place, end due to the cause(s) and menner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Yeer)
	O.C.M.E.	October 08, 1998

30. Neme end eddress of person who completed cause of death (Item 23a) (Type, Print)
J. LARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 13 1998	Geneva G. Sparks

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 87405

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Margaret E. Shrieves
2. Dete of Deeth: Month Nov. Dey 17, Yeer 1998
3. Time of Death: 8:10 AM
4e. Fecility Neme (If not institution, give street end number): 408 Woodview Square Apt. C
4b. City, Town, or Location of Deeth: Salisbury
4c. County of Deeth: Wicomico

Funeral Director

5. Sociel Security Number: 214-18-4799
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. lest birthday): 73 Yrs.
If Under 1 Year: Months / Deys
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 2-4-1925
9. Birthplace (State or Foreign Country): Va.

Usual Residence of Decedent

10a. State: Md.
10b. County: Wicomico
10c. City, Town or Location: Salisbury
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street end Number: 408 Woodview Square Apt. C
10f. Zip Code: 21804
10g. Citizen of What Country? USA

11. Maritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 College (1-4or 5+):
16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Home

17. Father's Neme (First, Middle, Last): Walter J. Mears
18. Mother's Name (First, Middle, Maiden Surneme): Mary E. Chance Mears

19a. Informant's Neme/Relationship (Type, Print): Angela Parsons, Daughter
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 408 Woodview Square Apt. C Salisbury, Md. 21804

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other (Specify) Entombment
20b. Place of Disposition (Name of cemetery, cremetory or other piece): Wicomico Memorial Park
Dete: 11-19-98
20c. Location - City or Town, Stete: Salisbury, Md.

21. Signeture of Funeral Service Licensee: William M. Short
22. Neme end Address of Facility: Short Funeral Home, Inc. 13 E. Grove St. Delmar, De. 19940

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert failure. List only one cause on each line.

Approximete Interval Between Onset and Death

Immediate Ceuse (Finel diseese or condition resulting in deeth): e. Chronic obstructive Lung Disease — 5 yrs

Due to (or es e consequence of): b. Coronary Artery Disease — "

Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Ceuse (Diseese or injury thet initiated events resulting in death) Lest

Due to (or es e consequence of): c. Congestive Heart Failure — "

Due to (or as a consequence of): d. Hypertension — "

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was en eutopsy performed? 1☐ Yes 2☐ No

24b. Were eutopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice

27. Manner of Death: 1☒ Nelurel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28e. Dete of Injury (Month, Day Yeer)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physicien:** To the best of my knowledge, death occurred et the time, date end piece, end due to the ceuse(s) end menner es steted. 2☐ **Medicel Exeminer:** On the besis of exemination end/or Investigation, in my opinion, death occurred et the time, dete end place, end due to the ceuse(s) and menner steted.

29b. Signeture end title of certifier: Robert Brandon, D.O
29c. License number: 33423183
29d. Date signed (Month, Dey, Yeer): 11-18-98

30. Neme end eddress of person who completed cause of death (Item 23a) (Type, Print): Robert Brandon, DO 1201 Pemberton Dr. Salisbury MD 21801

State Registrar

31. Dete filed (Month, Day, Yeer): NOV 20 1998
32. Registrer's Signeture: Geneva G Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37466

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Molly Wilson Trimble
2. Dete of Deeth — Month: Octomber — Dey: 6 — Yeer: 1998
3. Time of Deeth: 7:10 AM
4e. Feclity Neme *(If not institution, give street end number)*: St. Mary's Hospital
4b. City, Town, or Location of Deeth: Leonardtown
4c. County of Deeth: St. Mary's

Funeral Director

5. Social Security Number: 058-14-4397
6. Sex: 1☐ M 2■ F
7. Age *(In yrs. lest birthday)*: 87 Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Dey, Yeer)*: February 19, 1911
9. Birthplace *(State or Foreign Country)*: New Jersey

Usuel Residence of Decedent

10a. Stete: Maryland
10b. County: St. Mary's
10c. City, Town or Location: California
10d. Inside City Limits: 1☐ Yes 2■ No
10e. Street end Number: 23240 Chestnut Oak #1043
10f. Zip Code: 20619
10g. Citizen of Whet Country?: United States

11. Maritel Status: 1☐ Never Married 2☐ Married 3■ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2■ No If Yes, Give Year or Detes:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2■ No *Specify:*
14. Race - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12 — College (1-4or 5+):
16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Journalist
16b. Kind of Business/Industry: Journalism

17. Fether's Name *(First, Middle, Last)*: William Turner Wilson
18. Mother's Name *(First, Middle, Meiden Surneme)*: Mary Blanchard

19a. Informant's Name/Relationship *(Type, Print)*: William W. Lanigan, Son
19b. Meiling Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 361 Vanderveer Avenue, Somerville, NJ 08876-3360

20a. Method of Disposition: 1☐ Burial 2■ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, crematory or other piece)*: Metropolitan Crematory — Date: 10-7-98
20c. Location - City or Town, Stete: Alexandria, Virginia

21. Signeture of Funeral Service Licensee: Edward N. Brinsfield, JR. M00052
22. Neme and Address of Feclity: Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 20650

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications thet ceused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one cause on eech line. — Approximate Interval Between Onset end Deeth

Immediate Ceuse (Finel disease or condition resulting in death): a. Metastatic Carcinoma Recto sigmoid colon
Due to (or es e consequence of):

Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury thet initieted events resulting in death) Lest:
b.
Due to (or es e consequence of):
c.
Due to (or es e consequenca of):
d.

Pert II. **Other eignificant conditions** contributing to deeth but not resulting in the underlying ceuse given in Part I.: Pelvic abscess, recent UTI; Unstable angina Pectoris

23b. Did tobacco use contribute to the cauee of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1☐ Yes 2☒ No

25. Wes cese referred to medical exeminer? 1☐ Yes 2☒ No

26. Piece of Deeth *(Check only one)*: Hospital: 1☒ Inpetient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Dete of Injury *(Month, Dey Yeer)*
28b. Time of Injury
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted. 2☐ **Medicel Examiner:** On the basis of exemination end/or investigation, In my opinion, deeth occurred et the time, date end place, and due to the ceuse(s) end manner stated.

29b. Signeture and title of certifier:
29c. License number: D19917
29d. Date signed *(Month, Dey, Yeer)*: 10/6/98

30. Neme and address of person who completed cause of death (Item 23e) (Type, Print): JAMES C. BOYD M.D. 2050 WILDWOOD CTR. CALIFORINA,MD. 20619

State Registrar

31. Date filed *(Month, Dey, Yeer)*: OCT 07 1998
32. Registrer's Signeture: Brenda G. Baker

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

MOLLY WILSON TRIMBLE

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37467

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*	2. Date of Death Month / Day / Year	3. Time of Death
William Spencer Wood, Sr.	October 1, 1998	11:00 PM

4a. Facility Name *(If not institution, give street and number)*	4b. City, Town, or Location of Death	4c. County of Death
41430 New Market Turner Road	Mechanicsville	St. Mary's

Funeral Director

5. Social Security Number	6. Sex	7. Age *(In yrs. last birthday)*	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth *(Month, Day, Year)*	9. Birthplace *(State or Foreign Country)*
213-18-7490	1☒ M 2☐ F	78 Yrs.			February 15,1920	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	St. Mary's	Mechanicsville	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
41430 New Market Turner Road	20659	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☒ Yes 2☐ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No *Specify:*	*Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*		16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*	16b. Kind of Business/Industry
Elementery/Secondary (0-12)	College (1-4or 5+)		
7th		Power Plant Operator	U.S. Government

17. Father's Name *(First, Middle, Last)*	18. Mother's Name *(First, Middle, Maiden Surname)*
Herman Oliver Wood Sr.	Mary I. Pilkerton

19a. Informant's Name/Relationship *(Type, Print)*	19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*
Agnes L. Wood/Wife	41430 New Market Turner Road, Mechanicsville, MD 20659

20a. Method of Disposition	20b. Place of Disposition *(Name of cemetery, crematory or other place)*	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*	Queen of Peace Cemetery	10/5/98	Helen, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Michael Kevin Gardiner Jr	Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Cardiac arrhythmia

Due to (or as e consequenca of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Generalized carcinomatosis

Due to (or as e consequence of):
c.

Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?	24a. Wes en eutopsy performed?	24b. Were autopsy findings available prior to compteion of cause of death?
1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown	1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death *(Check only one)*	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death	28a. Date of Injury *(Month, Day Year)*	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*	28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed *(Month, Day, Year)*
▶ L Berube MD,	D00506	October 2, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Leon Berube, MD Mechanicsville, MD 20659

State Registrar

31. Date filed *(Month, Day, Year)*	32. Registrar's Signature
OCT 02 1998	Geneva G. Sparks

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: CHARLES THEODORE WHAYLAND

2. Date of Death Month: 11 Day: 22 Year: 98

3. Time of Death: 1617

4a. Facility Name *(If not institution, give street and number)*: 101 WHAYLAND DRIVE

4b. City, Town, or Location of Death: HEBRON

4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 213-14-1158

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 75 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 03-03-23

9. Birthplace *(State or Foreign Country)*: DELAWARE

Usual Residence of Decedent

10e. State: MD

10b. County: WICOMICO

10c. City, Town or Location: HEBRON

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 101 WHAYLAND DR.

10f. Zip Code: 21830

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: NAVY WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: PARTS MANAGER

16b. Kind of Business/Industry: AUTO DEALERSHIP

17. Father's Name *(First, Middle, Last)*: WAKEMAN W. WHAYLAND

18. Mother's Name *(First, Middle, Maiden Surname)*: BERNICE M. HADDOCK

19a. Interment's Name/Relationship *(Type, Print)*: SARA M. WHAYLAND - WIFE

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 101 WHAYLAND DR. HEBRON, MD 21830

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: CAMBRIDGE CREMATORY

Date: 11-23-98

20c. Location - City or Town, State: CAMBRIDGE, MD

21. Signature of Funeral Service Licensee: ▶ B. Keith Phipps, CFSP

22. Name and Address of Facility: BOUNDS FUNERAL HOME, INC. 705 E. MAIN ST. SALISBURY, MD 21804

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. CHRONIC OBSTRUCTIVE LUNG DISEASE — YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CORONARY ARTERY DISEASE; HYPERTENSION

23b. **Did tobacco use contribute to the cause of death?** 1☐ **Yes** 2☐ No 3☐ **Probably** 4☒ **Unknown**

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John T. Bulkeley

29c. License number: D0003599

29d. Date signed *(Month, Day, Year)*: 11-23-98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOHN T. BULKELEY, M.D., 108 PINE BLUFF ROAD, SALISBURY MD 21801

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

lot 1UA

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 23 1998

32. Registrar's Signature: ▶ Geneva B Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37469

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): RUTH SCOTT WILLOUGHBY
2. Date of Death (Month, Day, Year): NOVEMBER 21 1998
3. Time of Death: 8:20 PM
4a. Facility Name (If not institution, give street and number): BERLIN NURSING & REHABILITATION CENTER
4b. City, Town, or Location of Death: BERLIN
4c. County of Death: WORCESTER

Funeral Director

5. Social Security Number: 218-20-4361
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MARCH 8,1909
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: WORCESTER
10c. City, Town or Location: BERLIN
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 9715 HEALTHWAY DRIVE
10f. Zip Code: 21811
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): MORTICIAN
16b. Kind of Business/Industry: DEATH CARE

17. Father's Name (First, Middle, Last): DANIEL ELEXANDER SCOTT
18. Mother's Name (First, Middle, Maiden Surname): ROSE EFFIE BASSETT

19a. Informant's Name/Relationship (Type, Print): MABEL HOLLAND/SISTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10609 ASSATEAGUE ROAD, BERLIN, MARYLAND 21811

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): EAST NEW MARKET CEMETERY
Date: 11/24
20c. Location - City or Town, State: EAST NEW MARKET, MD

21. Signature of Funeral Service Licensee: Leonard D. Zeller
22. Name and Address of Facility: ZELLER FUNERAL HOME, P. O. BOX 207, 106 MAIN STREET, EAST NEW MARKET, MD 21631

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. FEVER of UNKNOWN ORIGIN	1½ WEEKS
Due to (or as a consequence of):	b. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Edwin Castaneda MD
29c. License number: D46257
29d. Date signed (Month, Day, Year): 11/23/98
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): EDWIN CASTANEDA, MD 9714 HEALTHWAY DR. BERLIN MD 21811 410-641-0646

State Registrar

31. Date filed (Month, Day, Year): NOV 25 1998
32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37470

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Alan Alfred Alessi

2. Date of Death: Month December Day 4 Year 1998

3. Time of Death: 5:28 PM

4a Facility Name (If not institution, give street and number): Genesis Eldercare Loch Raven Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 218-76-9891

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 51 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): October 17, 1947

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 3714 Evergreen Ave.

10f. Zip Code: 21206

10g. Citizen of What Country?: United States

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 0

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): not employed

16b. Kind of Business/Industry: N/A

17. Father's Name (First, Middle, Last): Aldo A. Alessi

18. Mother's Name (First, Middle, Maiden Surname): Rita R. Roberts

19a. Informent's Name/Reletionship (Type, Print): Antoinette Saglimbeni/sister

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 1826 Glen Ridge Rd. Baltimore, MD 21234

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removal from Stete 4 [ ] Donation 5 [ ] Other (Specify)

20b. Piece of Disposition (Name of cemetery, cremetory or other place): Gardens of Faith Cemetery

Dete: 12/8/98

20c. Location - City or Town, State: Overlea, MD

21. Signature of Funeral Service Licensee: Donna Stupka Kenaka

22. Name end Address of Facility: Mitchell-Wiedefeld Home, Inc. 6500 York Rd. Baltimore, MD 21212

Physician /Medical Examiner

23a. Pert1. Enter the diseese or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Deeth

Immediate Cause (Final diseese or condition resulting in death)

a. VIRAL Encephalitis

Due lo (or as a consequence of):

Sequentielly list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last

b. Sepsis

Due lo (or es e consequence of):

c.

Due lo (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributa to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was en autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings eveilable prior to completion of cause of death? 1 [ ] Yes 2 [✓] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Deeth (Check only one)

Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [✓] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Menner of Deeth: 1 [✓] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury et Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end piece, and due to the cause(s) end menner es stated. 2 [ ] **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) end manner stated.

29b. Signature and lite of certifier: [signature]

29c. License number: D52739

29d. Date signed (Month, Day, Year): Dec 8, 1998

30. Name end address of person who completed cause of death (Item 23a) (Type, Print): Suresh Shandelya 3007 E Northern Parkway Balt MD

State Registrar

31. Dete filed (Month, Day, Year): DEC 08 1998

32. Registrer's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37471

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: THOMAS ALBERT ANTLITZ, JR.

2. Date of Death (Month, Day, Year): DECEMBER 05 1998

3. Time of Death: 8:45 PM

4a. Facility Name *(If not institution, give street and number)*: NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death: GLEN BURNIE

4c. County of Death: ANNE ARUNDEL CO.

Funeral Director

5. Social Security Number: 705-05-2377

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 20 1908

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decadant

10a. State: Md.

10b. County: n/a

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 1619 Jackson Street

10f. Zip Code: 21230

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 6 | College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Engineer

16b. Kind of Business/Industry: B & O Railroad

17. Father's Name *(First, Middle, Last)*: Thomas A. Antlitz, Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Bertha Kunde

19a. Informant's Name/Relationship *(Type, Print)*: Margaret M. Antlitz (Wife)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1619 Jackson Street, Baltimore, Md. 21230

20a. Method of Disposition: [X] 1 Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Cedar Hill Cemetery

Date: Dec.08 1998

20c. Location - City or Town, State: Brooklyn Park, Md.

21. Signature of Funeral Service Licensee: David A. Naylor

22. Name and Address of Facility: McCully-Polyniak Funeral Home 130 E. Fort Ave. Baltimore, Md. 21230

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Acute myocardial infarction — 1 Day

Due to (or as a consequence of):
b. Carcinoma Prostate with Metasis. — 10 yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [✓] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [✓] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [✓] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D14136

29d. Date signed *(Month, Day, Year)*: 12.7.98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Suite 201 Crain Towers Glen Burnie md 21061

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 08 1998

32. Registrar's Signature: Denise B. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37472

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARGARET ELEANOR ACREE

2. Date of Death (Month, Day, Year): December 2, 1998

3. Time of Death: 3:51 pm

4a. Facility Name (If not institution, give street and number): STELLA MARIS HOSPICE AT MERCY

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 214-01-7211

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 82 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb. 28 1916

9. Birthplace (State or Foreign Country): Maryland

Usual Residance of Decedant

10a. State: Md.

10b. County: Anne Arundel Co.

10c. City, Town or Location: Pasadena

10d. Insida City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 8454 Geneva Road

10f. Zip Code: 21122

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yas 2☒ No If Yas, Give Yaar or Datas: X

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedant's Education (Specify only highest grada completed)

Elementary/Secondary (0-12): 10

College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Assembly worker

16b. Kind of Businass/Industry: Chespeake Instrument

17. Fathar's Nama (First, Middle, Last): Charles T. Yearsley, Sr.

18. Mother's Name (First, Middle, Maiden Surnama): Ella E. Mesick

19a. Informant's Name/Relationship (Type, Print): Jacqueline Acree Horst (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8454 Geneva Road, Pasadena, Md. 21122

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from Stata 4☐ Donation 5☐ Othar (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Glen Haven Memorial Pk.

Date: Dec. 07 1998

20c. Location - City or Town, Stata: Glen Burnie, Md.

21. Signatura of Funaral Sarvice Licansea: John F. Ellis

22. Name and Address of Facility: McCully-Polyniak Funeral Home 3204 Mountain Road, Pasadena, Md. 21122

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complications that caused tha death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or haart failura. List only ona causa on aach lina.

Approximata Interval Batween Onset and Daath

Immediata Causa (Final disaasa or condition rasulting in daath)

a. Non Hodgkins Lymphoma — 7 years

Dua to (or as a consequence of):

Sequentially list conditions, if any, laading to immadiata cause. Entar Undarlying Causa (Diseasa or Injury that initiated avants rasulting in death) Last

b. Dua to (or as a consequence of):

c. Dua to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings available prior to completion of cause of death? 1☐ Yas 2☒ No

25. Was casa refarred to medical examiner? 1☐ Yas 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) HOSPICE

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Panding Investigation 6☐ Could not be datarmined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Cartifiar (Check only one): 1☒ Certifying Physician: To tha best of my knowledge, death occurred at the time, date and place, and dua to tha cause(s) and mannar as stated. 2☐ Medical Examiner: On tha basis of axamination and/or investigation, in my opinion, death occurred at tha time, date and place, and due to the cause(s) and mannar stated.

29b. Signatura and titla of cartifiar: MD

29c. License number: D40854

29d. Data signed (Month, Day, Year): DECEMBER 3, 1998

30. Name and address of person who complatad causa of death (Item 23a) (Type, Print): DAVID RISEBERG 301 St Paul Place, Baltimore MD 21202

State Registrar

31. Data filed (Month, Day, Year): DEC 08 1998

32. Registrar's Signatura: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Margaret Acree

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

6

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 37473

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Albert J Ames

2. Date of Death: Month 12 Day 6 Year 98

3. Time of Death: 3:AM

4e. Facility Name *(If not institution, give street and number)*: 639 N. Woodington Road

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

Funeral Director

5. Social Security Number: 213-28-6568

6. Sex: 1 ☑ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 67 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 4-10-31

9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County:

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 ☑ Yes 2 ☐ No

10e. Street and Number: 639 N. Woodington Road

10f. Zip Code: 21229

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 6TH | College (1-4or 5+):

16e. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Coke Oven

16b. Kind of Business/Industry: Beth Steel

17. Father's Name *(First, Middle, Last)*: Elmer Bordley

18. Mother's Name *(First, Middle, Maiden Surname)*: Gertrude Howard

19a. Informent's Name/Relationship *(Type, Print)*: Nettie Ames

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 639 N. Woodington Road, Balto, Md. 21239

20a. Method of Disposition: 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metro Crematory

Date: 12/8/98

20c. Location - City or Town, State: Balto. MD

21. Signature of Funeral Service Licensee: Jeff Miller

22. Name and Address of Facility: Jeff Miller P.C. F/H 1639 N. Broadway Balto. Md. 21213

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Respiratory Arrest	Immed
Due to (or as a consequence of): b.	Chronic Renal Failure	3 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last. Due to (or as a consequence of): c.	Hypertension	10 y
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Gastric Carcinoma

NIDDM

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☑ Netural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D35309

29d. Date signed *(Month, Day, Year)*: 12/7/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Sandra Sattin MD 2850 N Ridge Rd Ellicott City 21043

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 08 1998

32. Registrar's Signature: G. Sparks

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 374 74

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Anna M. Balbier

2. Date of Death (Month, Day, Year): December 5, 1998

3. Time of Death: 2:05 P.M.

4a. Facility Name (If not institution, give street and number): 8401 Dogwood Road

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212-05-0008

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 23, 1910

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐ Yes 2☐ No

10e. Street and Number: 8401 Dogwood Road

10f. Zip Code: 21244

10g. Citizen of What Country?: United States

11. Maritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 1☐ Yes 2☒ No Specify:

14. Race - Americen Indian, Black, White, etc. Specify: White

15. Decedent's Educetion (Specify only highest grede completed): Elementary/Secondary (0-12): 12th Grade | College (1-4or 5+):

16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Telephone Operator

16b. Kind of Business/Industry: C & P Telephone Co.

17. Father's Name (First, Middle, Lest): Girolamo Talluto

18. Mother's Name (First, Middle, Maiden Surname): Rosario Todaro

19e. Informent's Name/Relationship (Type, Print): Betty Reincke - Niece

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 8401 Dogwood Road; Baltimore, Maryland 21244

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other place): Dulaney Valley Mem. Gdns.

Date: 12/8/98

20c. Location - City or Town, State: Timonium, Maryland

21. Signature of Funeral Service Licensee: ▶ James F. Hackney Jr.

22. Name and Address of Facility: Loring Byers Funeral Directors, Inc. 8728 Liberty Road; Randallstown, Maryland 21133

Physician /Medical Examiner

23a. Pert I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heert feilure. List only one ceuse on eech line.

Approximate Intervel Between Onset end Death

Immediete Cause (Final disease or condition resulting in death): e. Breast cancer with metastases

Due to (or es e consequence of):

Sequentially list conditions, if eny, leading to immediete ceuse. Enter Underlying Cause (Disease or Injury thet initiated events resulting in deeth) Last

b.

Due to (or as e consequence of):

c.

Due to (or as e consequence of):

d.

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Plece of Deeth (Check only one): Hospital: 1☐ Inpetient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physicien:** To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end manner es steted. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) and manner stated.

29b. Signature end title of certifier: ▶ T. Kawaja

29c. License number: D25112

29d. Date signed (Month, Dey, Yeer): 12/7/1998

30. Name end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print): TAHOORA KAWAJA 1777, Reisterstown Rd #108 Baltimore MD 21208

State Registrar

31. Date filed (Month, Dey, Yeer): DEC 08 1998

32. Registrar's Signeture: Geneva G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other then 'natural', or items 23e or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the deeth certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37475

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: William Ben Brown

2. Date of Death (Month, Day, Year): DECEMBER 1, 1998

3. Time of Death: 8 30 PM

4a. Facility Name *(If not institution, give street and number)*: Stella Maris @ Mercy Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 247-26-6316

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 92 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: NOV. 20, 1906

9. Birthplace *(State or Foreign Country)*: South Carolina

Usual Residence of Decedent

10a. State: Md.

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 1300 Lanvale St., Apt. #512

10f. Zip Code: 21213

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indien, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): unknown; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Railroad Worker

16b. Kind of Business/Industry: Railroad

17. Father's Name *(First, Middle, Last)*: Unavailable

18. Mother's Name *(First, Middle, Maiden Surname)*: Eliza Burrows

19a. Informent's Name/Relationship *(Type, Print)*: Jack Brown - brother

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: RR4, Box 281A, Kingstree, S. C. 29556

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Antioch Baptist Cemetery — Date: 12/05/98

20c. Location - City or Town, State: Kingstree, S. C.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility: Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 7250 Washington Blvd., Elkridge, Md. 21075

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List *only* one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Ceuse (Final disease or condition resulting in death)	a. Colon Cancer	3 years
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings eveileble prior to completion of causa of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other *(Specify)* HOSPICE — STELLA MARIS AT MERCY

27. Manner of Death: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as steted. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Dr. Rubin MD

29c. License number: D40854

29d. Data signed *(Month, Day, Year)*: DECEMBER 2, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAVID RISEBERG 301 St Paul Pl BALTIMORE MD 21202

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 08 1998

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

William BROWN

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 37476

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Joseph Bogner
2. Date of Death (Month, Day, Year): 11/26/98
3. Time of Death: 10:30am
4a. Facility Name (If not institution, give street and number): 447 Brunswick Street
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219-07-3633
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 2/17/16
9. Birthplace (State or Foreign Country): Kentucky

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 447 Brunswick Street
10f. Zip Code: 21223
10g. Citizen of What Country? United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Sheet Metal
16b. Kind of Business/Industry: Steel Company

17. Father's Name (First, Middle, Last): George Bogner
18. Mother's Name (First, Middle, Maiden Surname): Unknown

19a. Informant's Name/Reletionship (Type, Print): Revia M. Bogner/wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 447 Brunswick Street Baltimore, Maryland 21223

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removel from State 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or other place): Loudon Park Cemetery
Date: 11/30/98
20c. Location - City or Town, Stete: Baltimore, Maryland

21. Signeture of Funeral Service Licensee: Teresa K Lg
22. Name and Address of Facility: Hubbard Funeral Home 4107 Wilkens Avenue Baltimore, Maryland 21229

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Cancer of the lung. (Bronchogenic)	7m.
Due to (or as a consequence of): b.	C.O.P.D.	Years.
Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last — Due to (or as a consequence of): c.	C.A.D.	Years.
d.	Chronic Lymphocytic Leukemia	Years.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension.
Peripheral Vascular disease.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Naturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) and manner stated.
29b. Signature and title of certifier: Ataollah Golpira, MD
29c. License number: D0002191
29d. Date signed (Month, Day, Year): 11/30/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ATAOLLAH GOLPIRA, MD. 3029 Dundalk ave Baltimore, MD. 21222

State Registrar

31. Date filed (Month, Day, Year): DEC 08 1998
32. Registrar's Signature: G. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

8X1

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37477

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOHN HENRY BUENGER
2. Date of Death (Month, Day, Year): DECEMBER 4, 1998
3. Time of Death: 8:15 A.M.
4a. Facility Name (If not institution, give street and number): 335 KINGSBURY WAY - BUILDING 11-UNIT 12
4b. City, Town, or Location of Death: WESTMINSTER
4c. County of Death: CARROLL COUNTY

Funeral Director

5. Social Security Number: 219-18-6587
6. Sex: 1 [X] M 2 [ ] F
7. Age (If yrs. last birthday): 72 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): NOV 14, 1926
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: CARROLL
10c. City, Town or Location: WESTMINSTER
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 335 KINGSBURY WAY - BLDG-11 UNIT-12
10f. Zip Code: 21157
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12TH GRADE | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): POLICE OFFICER
16b. Kind of Business/Industry: BALTIMORE CITY

17. Father's Name (First, Middle, Last): LEO BUENGER
18. Mother's Name (First, Middle, Maiden Surname): WILHELMINA BOSSE

19a. Informent's Name/Ralationship (Type, Print): DOLORES BUENGER (WIFE)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 336 KINGSBURY WAY - BUILDING-11-UNIT-12-WESTMINSTER, MARYLAND 21157

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removal from Stete 4 [ ] Donation 5 [ ] Othar (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): CEDAR HILL CEMETERY | Date: 12/7/98
20c. Location - City or Town, State: BALTIMORE

21. Signature of Funeral Service Licensee: Jackie D. Shannon
22. Name and Address of Facility: HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE - BALTIMORE, MARYLAND 21229

Physician /Medical Examiner

23a. Part I. Enter the disaase, or complications that caused tha daath. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heert feilure. List only ona causa on each line.

Approximete Interval Between Onset and Death

Immediate Cause (Final diseese or condition resulting in death)
a. CEREBROVASCULAR ACCIDENT — 4 HOURS
Due to (or es a consequence of):
b. SEVERE CEREBROVASCULAR INSUFFICIENCY

Sequentially list conditions, if any, leeding to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: RECURRENT STROKES, SEVERE CORONARY ARTERY DISEASE, MULTIPLE PREVIOUS MYOCARDIAL INFARCTIONS, DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was casa raferrad to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Mennar of Death: 1 [X] Natural 2 [ ] Accidant 3 [ ] Suicide 4 [ ] Homicida 5 [ ] Pending investigation 6 [ ] Could not be datarminad
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28a. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29b. Signature end title of cartifier: ATTENDING
29c. License number: D16200
29d. Date signed (Month, Day, Year): DECEMBER 4, 1998

30. Name and address of person who complated causa of death (Item 23a) (Type, Print): DR. NORBERTO M. MACHIRAN - 720 MAIDEN CHOICE LANE - SUITE C-CATONSVILLE, MARYLAND 21228

State Registrar

31. Date filed (Month, Day, Year): DEC 08 1998
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

10+1

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37478

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Leona F. Burg	DECEMBER 06 1998	05:46AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
THE JOHNS HOPKINS HOSPITAL	BALTIMORE CITY	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Data of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-18-9490	1☐ M 2☒ F	77 Yrs.			Sept. 10, 1921	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	N/A	Baltimore City	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1449 Andre Street	21230	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, atc.)	14. Race - American Indian, Black, Whita, atc.
1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yas, Giva Year or Detes:	1☐ Yas 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired)	16b. Kind of Businass/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
6th Grade	N/A	Housekeeper	Cleaning

17. Father's Nama (First, Middle, Last)	18. Mothar's Nama (First, Middle, Maiden Surnama)
Nicholas Burg	Elizabeth Tyson

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code)
Margaret A. Holcomb / Sister	1449 Andre Street Baltimore MD 21230

20a. Mathod of Disposition	20b. Place of Disposition (Nama of cemetery, crematory or othar place)	Data	20c. Location - City or Town, Stata
1☒ Burial 2☐ Cremation 3☐ Removal from Stata 4☐ Donation 5☐ Other (Specify)	Glen Haven Cem.	Dec. 9, 1998	Baltimore Maryland

21. Signature of Funaral Service Licensee: Victor P. Doda, Jr.

22. Nama and Address of Facility: Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore MD 21230

Physician /Medical Examiner

23a. Part I. Entar tha disaase, or complications thet caused the death. Do not entar the moda of dying, such es cardiac or respiratory arrest, shock, or heart failura. List only ona cause on each line.

		Approximata Interval Between Onset and Death
Immediata Causa (Final disaase or condition resulting in death) a.	Metabolic Acidosis and hyperKalemia	24-30 hours
Dua to (or as a consequence of): b.	Sepsis	2 weeks
Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last. Dua to (or as a consequence of): c.	Renal Failure	one month
Dua to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.

Atrial Fibrillation, heart failure history with poor heart function, chronic obstructive pulmonary disease

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Wara autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yas 2☐ No

25. Was casa referred to medical examiner?	26. Placa of Death (Check only one)	
1☐ Yas 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Homa 5☐ Rasidence 6☐ Othar (Specify)

27. Mannar of Death	28a. Data of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending investigation 6☐ Could not be detarmined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Cartifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the tima, data and place, and due to tha cause(s) and manner as stated. 2☐ **Medical Examiner:** On tha basis of examination and/or investigation, in my opinion, death occurred at the tima, data and place, and due to tha cause(s) and mannar stated.

29b. Signeture end title of certifier	29c. License number	29d. Data signed (Month, Day, Year)
Kristen L Fernandez	P10877	December 6, 1998

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): Kristen L. Fernandez 600 N. Wolfe St. Baltimore MD 21287

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 08 1998	Jenna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37479

ITEMS: #20A-C PER F.A. G766 12-11-98 WR.

BERDAR, GERTRUDE

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
GERTRUDE HELEN BERDAR	December 6, 1998	10:46 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
ER FALLSTON GEN HOSPITAL	FALLSTON	HARFORD

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
169-03-1432	1☐ M 2☒ F	82 Yrs.			10/06/1916	PENNSYLVANIA

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
PA	ALLEGHENY	BETHEL PARK	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1337 CENTERMAN AVENUE	15102	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Yeer or Detes:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10		HOMEMAKER	OWN HOME

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
STANISLAUS SCHROEPFER	CATHERINE LANG

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
KATHLEEN DUCHESNE/DAUGHTER	1705 GILLINGHAM BEL AIR, MD 21015

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory, or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	PITTSBURG CREMATION SERVICE QUEEN OF HEAVEN	12/10/98	PITTSBURGH, PA ~~PETERS TWSP., PA.~~

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Phillip Hook	STERLING-ASHTON-SCHWAB FUNERAL HOME, INC. 736 EDMONDSON AVE. CATONSVILLE, MD 21228

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart tailure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediete Cause (Finel disease or condition resulting in death)
a. ADWD.

Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or es e consequence of):
c.

Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CA BREAST

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒ Yes 2☐ No	Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Dete of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined	NA	NA M	NA 1☐ Yes 2☐ No	NA

28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
NA	NA

29a. Certifier (Check only one)
1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner**: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ DME	OCME	DEC 6 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
GPRABHU MD 218 GILFORD AVE BELAIR MD 21014

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 08 1998	▶ G. Sparks

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37480

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Edward J. Broaders
2. Date of Death: Month Dec, Day 1, Year 1998
3. Time of Death: 3:46 PM
4a. Facility Name (If not institution, give street and number): Genesis ElderCare - The Pines
4b. City, Town, or Location of Death: Easton
4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 214-18-7441
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 80 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): July 20, 1918
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10e. State: Maryland
10b. County: Caroline Co.
10c. City, Town or Location: Denton
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 506 South 5th Ave.
10f. Zip Code: 21629
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 5; College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Merchant Seaman
16b. Kind of Business/Industry: Seafarer Union

17. Father's Name (First, Middle, Last): Harry Broaders
18. Mother's Name (First, Middle, Maiden Surname): Alice Traver

19e. Informant's Name/Relationship (Type, Print): Anna M. Broaders Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 506 South 5th Ave. Denton, Maryland 21629

20e. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetary, cremetory or other place): Glen Haven Mem. Park
Date: Dec. 4, 1998
20c. Location - City or Town, State: Glen Burnie, Maryland

21. Signature of Funeral Service Licensee: John F. Collins
22. Name and Address of Facility: McCully-Polyniak Funeral Home 3204 Mountain Road Pasadena, Maryland 21122

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Pneumonia — days
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Cerebrovascular accident — weeks
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part ff. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Atherosclerosis

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D25933
29d. Date signed (Month, Day, Year): 12-2-98

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Michael Crowley, MD 508 Idlewild Avenue Easton, MD 21601

State Registrar

31. Date filed (Month, Day, Year): DEC 08 1998
32. Registrar's Signature: G. Hoard

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37481

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ELIZABETH FLEMING BLAKE

2. Dete of Death Month Day Yeer: NOVEMBER 28 1998

3. Time of Death: 1:15 PM

4e. Feclity Neme (If not institution, give street end numbar): FUTURE CARE OF THE CHESAPEAKE

4b. City, Town, or Location of Deeth: ARNOLD

4c. County of Deeth: ANNE ARUNDEL CO.

Funeral Director

5. Sociel Security Number: 243-32-6263

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 72 Yrs. | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Dey, Yeer): May 11 1926

9. Birthplece (State or Foraign Country): N. Carolina

Usual Residence of Decedant

10a. Stata: Md.

10b. County: Anne Arundel Co.

10c. City, Town or Location: Pasadena

10d. Insida City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 8334 Catherine Ave.

10f. Zip Code: 21122

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yes, Giva Year or Dates:

13. Was Decadent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Bleck, Whita, etc. Specify: black

15. Decedent's Education (Specify only highest grede completed): Elamantary/Secondary (0-12): 12 | Collaga (1-4or 5+): 3

16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife

16b. Kind of Business/Industry: Home Owner

17. Father's Neme (First, Middle, Last): James Lindsey Fleming

18. Mother's Name (First, Middle, Maidan Sumama): Connie Lucile Knox

19a. Informant's Name/Ralationship (Type, Print): William B. Blake (Husband)

19b. Mailing Addrass (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 8334 Catherine Ave., Pasadena, Md. 21122

20a. Mathod of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Othar (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other place): Cedar Hill Cemetery

Dete: Dec. 03 1998

20c. Location - City or Town, Stete: Brooklyn Park, Md.

21. Signatura of Funerel Service Licensaa: John F. Collins

22. Nama and Address of Facility: McCully-Polyniak Funeral Home 3204 Mountain Road, Pasadena, Md. 21122

Physician /Medical Examiner

23a. Part I. Enter the disaase, or complications thet caused tha death. Do not enter tha mode of dying, such es cerdiac or respiratory errest, shock, or haart failure. List only ona causa on aach lina.

		Approximeta Intarval Batwaan Onset and Deeth
Immedieta Causa (Final disaasa or condition resulting in deeth) e.	Renal Failure	1-2 years
Dua to (or es e consequenca of): b.	Pituitary Macroadenoma	DAYS
Sequantially list conditions, if any, leeding to immediata cause. Entar Underlying Cause (Disease or injury that initiatad avants resulting in daath) Last. Dua to (or as a consequence of): c.	History of Lung Cancer	Years
Dua to (or as a consequence of): d.	Hyper tension	Years

Part II. **Other eignificent conditions** contributing to death but not resulting in the underlying ceusa given in Part I.

23b. Did tobacco use contribute to the ceuee of deeth? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings eveilable prior to complation of ceuse of death? 1☐ Yas 2☒ No

25. Wes cese referrad to medicel axaminer? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatiant 2☐ ER/Outpetient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residance 6☐ Other (Specify)

27. Manner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28a. Place of Injury - At home, ferm, streat, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29a. Cartifiar (Check only one): ☒ 1 **Cartifying Phyeician:** To the best of my knowledga, death occurred et tha tima, data and place, and due to the cause(s) and menner as stated. ☐ 2 **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, daath occurred et the tima, date end place, and dua to tha causa(s) end manner statad.

29b. Signature and title of certifier: John F. Loome, M.D.

29c. License number: D52728

29d. Data signed (Month, Day, Yeer): 12/1/98

30. Nama and address of person who completed ceuse of deeth (Item 23a) (Typa, Print): John F. Loome, M.D. 1454 Baltimore and Annapolis Blvd, Arnold, MD 21012

State Registrar

31. Dete filed (Month, Day, Year): DEC 08 1998

32. Registrer's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

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Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

5

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37482

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ELWOOD BLACK
2. Date of Death Month DECEMBER Day 03 Year 1998
3. Time of Death: 3 AM
4e. Facility Name *(If not institution, give street and number)*: 1596 COLONY ROAD
4b. City, Town, or Location of Death: PASADENA
4c. County of Death: ANNE ARUNDEL CO.

Funeral Director

5. Social Security Number: 196-14-9763
6. Sex: 1☒M 2☐F
7. Age *(In yrs. last birthday)*: 72 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: May 26 1926
9. Birthplace *(State or Foreign Country)*: Penna.

Usual Residence of Decedent

10a. State: Md.
10b. County: Anne Arundel Co.
10c. City, Town or Location: Pasadena
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 1596 Colony Road
10f. Zip Code: 21122
10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 9; College (1-4or 5+): 0
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Home Builder
16b. Kind of Business/Industry: Construction Co.

17. Father's Name *(First, Middle, Last)*: Doyle Black
18. Mother's Name *(First, Middle, Maiden Surname)*: Ode Brown

19a. Informant's Name/Relationship *(Type, Print)*: Velma Black (Wife)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1596 Colony Road, Pasadena, Md. 21122

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: Green Mount Cemetery
Date: Dec 05 1998
20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: Daniel A. Naylor
22. Name and Address of Facility: McCully-Polyniak Funeral home 3204 Mountain Road, Pasadena, Md. 21122

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Emphysema. — 1969.
Due to (or as a consequence of): Smoking — 1940's

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of): "Black Lung" — 1940's
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Coronary Artery Disease.

23b. Did tobacco use contribute to the cause of death? 1☒Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No
26. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 6☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Ian Shantz MD
29c. License number: D 36203 (MD)
29d. Date signed *(Month, Day, Year)*: 12-4-98
30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Dr. Ian Shantz. 4191 Mountain Rd, Pasadena MD 21122

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 08 1998
32. Registrar's Signature: Geneva G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item: #17 Per FH Film G766 12-8-98RC

Certificate of Death

Reg. No. 98 37483

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ALVIN M BRAVERMAN
2. Dete of Death Month Day Yeer: December 2, 1998
3. Time of Deeth: 11:12 AM
4e. Feclity Neme (If not institution, give street and number): Sinai Hospital of Baltimore
4b. City, Town, or Location of Deeth: Baltimore
4c. County of Deeth: N/A

Funeral Director

5. Social Security Number: 216-32-4433
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 62 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Yeer): AUG 25 1936
9. Birthplace (Stete or Foreign Country): MARYLAND

Usual Residence of Decedent

10e. Stete: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: [X] 1 Yes 2 [ ] No
10e. Street end Number: 2304 BRIGHTLEAF WAY
10f. Zip Code: 21209
10g. Citizen of Whet Country?: USA

11. Maritel Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indien, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grede completed): Elementery/Secondary (0-12): | College (1-4or 5+): 5+
16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): TAX ATTORNEY
16b. Kind of Business/Industry: AT LAW

17. Father's Name (First, Middle, Last): HERMAN S ~~BRAVAERMAN~~ BRAVERMAN
18. Mother's Name (First, Middle, Maiden Surname): BESSYE GROSSFELD

19a. Informant's Name/Relationship (Type, Print): MARTA BRAVERMAN (WIFE)
19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 2304 BRIGHTLEAF WAY BALTO., MD 21209

20a. Method of Disposition: 1 [X] Buriel 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): BALTIMORE HEBREW
Date: 12/4/98
20c. Location - City or Town, Stete: REISTERSTOWN, MD

21. Signature of Funeral Service Licensee: [signature]
22. Neme end Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD. PIKESVILLE, MD 21208

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications thet ceused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert failure. List only one ceuse on eech line.

Approximate Intervel Between Onset end Death

Immediete Ceuse (Finel disease or condition resulting in deeth):
e. Acute Leukemia — 2 days
Due to (or es e consequence of):
b. Myeloproliferative disorder — 4 years

Sequentielly list conditions, if eny, leeding to immediete ceuse. Enter Underlying Ceuse (Diseese or Injury thet initiated events resulting in deeth) Lest
Due to (or es e consequence of):
c.
Due to (or as e consequence of):
d.

Pert II. **Other elgnificant conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.: Clostridium Difficile infection

23b. **Did tobacco uee contribute to the cause of death?** 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24e. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No
24b. Were eutopsy findings eveiieble prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical exeminer? 1 [ ] Yes 2 [X] No
26. Piece of Deeth (Check only one): Hospital: 1 [X] Inpetient 2 [ ] ER/Outpetient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Deeth: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Yeer):
28b. Time of Injury: M
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred:
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify):
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete):

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner es steted. 2 [ ] **Medical Examiner:** On the basis of exemination end/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) end menner stated.

29b. Signeture and title of certifier: Michael Wiederkehr M.D.
29c. License number: P 12345
29d. Date signed (Month, Dey, Yeer): December 2, 1998

30. Neme and eddress of person who completed cause of deeth (item 23e) (Type, Print): Michael Wiederkehr Sinai Hospital of Baltimore

State Registrar

31. Date filed (Month, Day, Yeer): DEC 08 1998
32. Registrer's Signeture: [signature] G. Sparks

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

ALVIN BRAVERMAN Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

10

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37484

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year	3. Time of Death
HELEN	BRENNER	DECEMBER 5, 1998	6:30 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
NORTH OAKS HEALTH CENTER	BALTIMORE	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-12-7338	1☐ M 2☒ F	93 Yrs.			MARCH 13,1905	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	BALTIMORE	BALTIMORE	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
725 MT. WILSON LANE #10	21208	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		HOMEMAKER	OWN HOME

17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Sumeme)	
MORRIS	MILLER	ROSE	GOLDBERG

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
DAVID BRENNER / HUSBAND	725 MT. WILSON LANE #10 BALTIMORE, MD 21208

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	ARLINGTON CHIZUK AMUNO	12/6/98	BALTIMORE, MD

21. Signature of Funeral Service Licensee ▶ Scott M. Cutler

22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD – PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart feilure. List only one cause on eech line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in deeth)
a. Pneumonia.
Due to (or es a consequence of):
b. Congestive Heart Failure.
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Lest

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobecco uee contribute to the cauee of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performed?	24b. Were eutopsy findings available prior to completion of ceuse of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Wes case referred to medical examiner?	26. Plece of Deeth (Check only one)	
1☐ Yes 2☒ No	Hospitel: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA	Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Deeth	28a. Dete of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)			28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one) 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.
2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date and place, end due to the ceuse(s) end menner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)
▶ Christopher Johns	D53283	12/6/98

30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print)
Christopher Johns 1147 S. Hanover St. Baltimore MD 21230

State Registrar

31. Dete filed (Month, Dey, Year)	32. Registrer's Signeture
DEC 08 1998	Donna B. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural', or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

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Medical Certification: To Be Completed by Physician/Medical Examiner

15

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37485

EVELYN BROPHY

Physician /Medical Examiner

1. Decadent's Neme *(First, Middla, Last)*: Evelyn Helen Brophy

2. Data of Daath — Month: December Day: 6, Yaar: 1998

3. Tima of Death: 07.50P.M.

4a. Facility Nama *(If not institution, give street and number)*: Mariner Health of Glen Burnie

4b. City, Town, or Location of Daath: Glen Burnie

4c. County of Daath: Anne Arundel

Funeral Director

5. Social Sacurity Numbar: 216 20 5597

6. Sex: 1☐ M 2☒ F

7. Aga *(In yrs. last birthday)*: 83 Yrs. — If Under 1 Year: Months / Days — If Undar 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Yaar)*: April 2, 1915

9. Birthplaca *(Stata or Foreign Country)*: New York

Usual Rasidance of Decadent

10a. Stata: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Glen Burnie

10d. Inside City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 7355 Furnace Branch Road

10f. Zip Coda: 21060

10g. Citizen of What Country?: U.S.

11. Marital Status: 1☐ Navar Marriad 2☐ Married 3☐ Widowad 4☒ Divorcad

12. Was Decadent Ever in U.S. Armed Forcas? 1☐ Yas 2☒ No — If Yas, Giva Yaar or Datas:

13. Was Decadent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxicen, Puarto Rican, atc.): 1☐ Yes 2☒ No *Spacify:*

14. Race - American Indian, Black, Whita, atc. *Specify:* White

15. Decadent's Educetion *(Specify only highast grade completad)*: Elementary/Sacondary (0-12): College (1-4or 5+): 2 years

16a. Decadent's Usual Occupation *(Giva kind of work done during most of working life. DO NOT usa retired)*: Registered Nurse

16b. Kind of Businass/Industry: Hospital

17. Fathar's Nama *(First, Middla, Last)*: Fred Schait

18. Mothar's Nama *(First, Middla, Maidan Surnama)*: Edith Brien

19a. Informant's Name/Ralationship *(Typa, Print)*: William Brophy / son

19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, State, Zip Code)*: 307 Moonlight Court Baltimore, Maryland 21225

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Place of Disposition *(Nama of cametary, cramatory or othar place)*: Glen Haven Memorial Park

Data: 12/8/98

20c. Locatlon - City or Town, Stata: Glen Burnie, Maryland

21. Signatura of Funeral Service Licensee: Donna Bramerowski

22. Nama and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications thet caused tha daath. Do not antar tha moda of dying, such es cardiac or raspiretory errast, shock, or haart failura. List only ona causa on aach line.

Approximata Intarval Batween Onset end Death

Immadiata Causa (Final diseasa or condition resulting in death) a. CORONARY ARTERY DISEASE — 6YEARS

Dua to (or as a consequance of): b. ESSENTIAL HYPERTENSION — 15YEARS

Sequantially list conditions, if any, laading to immediata ceusa. Enter Undarlying Causa (Disease or injury that initiatad avants rasulting in death) Last

Dua to (or as a consaquanca of): c. DIABETES MELLITUS — 2YEARS

Dua to (or as a consaquanca of): d. CEREBROVASCULAR ACCIDENT — 2YEARS

Part II. **Other algnificant conditiona** contributing to death but not rasulting in tha undarlying causa givan in Part I.: SENILE DEMENTIA

23b. Did tobacco use contributa to tha cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings availabla prior to complation of ceusa of daath? 1☐ Yas 2☒ No

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case rafarred to madical examinar? 1☐ Yas 2☒ No

26. Placa of Daath *(Check only ona)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatiant 3☐ DOA — Other: 4☒ Nursing Homa 5☐ Rasidence 6☐ Other *(Specify)*

27. Manner of Daath: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding Investigation 6☐ Could not be datarminad

28a. Data of Injury *(Month, Day Yaar)*

28b. Time of injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28e. Place of Injury - At homa, farm, straat, factory, office building, atc. *(Specify)*

28f. Location *(Straat and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifiar *(Check only one)*: 1☒ **Certifying Phyaician:** To tha bast of my knowledga, death occurred at tha tima, data and placa, and dua to tha causa(s) and manner as stated. 2☐ **Medical Examinar:** On tha basis of axamination end/or invastigetion, in my opinion, daath occurred at tha tima, data and place, and dua to tha ceusa(s) and mannar stated.

29b. Signatura and title of certifiar: Harjit Singh M.D

29c. Licansa number: D 14160

29d. Data signed *(Month, Day, Yaar)*: December 06, 1998

30. Nama and address of parson who completed causa of daath (Item 29a) (Type, Print): HARJIT SINGH M.D. 5410 ARITCHIE HIGHWAY, BALTIMORE, MARYLAND — 21225

State Registrar

31. Date filad *(Month, Day, Yaar)*: DEC 08 1998

32. Registrar's Signatura: Dawn G. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37466

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Elmer Zepp Bowen

2. Dete of Deeth: Month: December Dey: 01 Yeer: 1998

3. Time of Death: 7:48pm

4e. Facility Neme (If not institution, give street and number): Oak Crest Care Center

4b. City, Town, or Location of Deeth: Parkville

4c. County of Deeth: Baltimore

Funeral Director

5. Sociel Security Number: 220-44-5719

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. lest birthday): 91 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Dey, Yeer): July 28, 1907

9. Birthplace (State or Foreign Country): Baltimore, Maryland

Usuel Residence of Decedent

10e. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Parkville

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street end Number: 8800 Walther Blvd. Apt. 3306

10f. Zip Code: 21234

10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Merried 3 [ ] Widowed 4 [ ] Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed)

Elementery/Secondery (0-12): 6 yrs.

College (1-4or 5+): n/a

16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Captain

16b. Kind of Business/Industry: Baltimore City Police Department

17. Father's Name (First, Middle, Last): Howard R. Bowen

18. Mother's Name (First, Middle, Maiden Surneme): Jeannie Ross

19e. Informent's Name/Relationship (Type, Print): Mr. William Bowen (Son)

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 2119 Buell Drive Fallston, Maryland 21047

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Gardens of Faith Cemetery

Dete: 12/4/98

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: E. F. Lassahn

22. Neme end Address of Fecility: E. F. Lassahn Funeral Home 11750 Belair Road Kingsville, Maryland 21087

To Be Completed by Funeral Director

Elmer Zepp Bowen
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23e. Pert1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Deeth

Immediete Ceuse (Finel diseese or condition resulting in deeth): e. Pneumonia — one week

Due to (or as e consequence of):

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury thet initiated events resulting in deeth) Lest:

b. Due to (or es e consequence of):

c. Due to (or as e consequence of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Atrial fibrillation

CVA

23b. **Did tobacco uee contribute to the cause of deeth?** 1 [ ] Yee 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medicel examiner? 1 [ ] Yes 2 [X] No

26. Piece of Deeth (Check only one): Hospital: 1 [ ] Inpetient 2 [ ] ER/Outpetient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Menner of Death: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28e. Dete of Injury (Month, Dey Yeer)

28b. Time of Injury M

28c. Injury et Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physicten:** To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. 2 [ ] **Medicet Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s) end manner stated.

29b. Signeture end title of certifier: MD

29c. License number: D43732

29d. Dete signed (Month, Dey, Yeer): December 2, 1998

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): Michael Harper, MD 8800 Walther Boulevard, Parkville, MD 21234

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

31. Date filed (Month, Dey, Yeer): DEC 08 1998

32. Registrar's Signeture: Geneva G. Sparks

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37487

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Lest)*: Willie R Burgess

2. Dete of Deeth — Month: December; Day: 6; Yaar: 1998

3. Time of Death: 6 45AM

4a Fecility Neme *(If not institution, give street and number)*: University of Maryland Hospital

4b. City, Town, or Location of Deeth: Baltimore

4c. County of Deeth: n/a

Funeral Director

5. Social Security Number: 250-60-5750

6. Sax: 1 XX M 2 ☐ F

7. Age *(In yrs. last birthday)*: 59 Yrs.

If Under 1 Yaar — Months: ; Days:

If Undar 24 Hrs. — Hours: ; Min.:

8. Data of Birth *(Month, Day, Year)*: May 15,1939

9. Birthplace *(State or Foreign Country)*: SC

Usuel Residence of Decedent

10a. State: MD

10b. County: n/a

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 XX Yes 2 ☐ No

10e. Street and Number: 4651 Pimlico Rd

10f. Zip Code: 21215

10g. Citizen of Whet Country?: USA

11. Marital Status: 1 ☐ Never Merried 2 XX Married 3 ☐ Widowed 4 ☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forcas? 1 ☐ Yas 2 XX If Yes, Give Year or Detes:

13. Wes Dacedant of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 1 ☐ Yes XX No *Specify:*

14. Race - American Indian, Bleck, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*

Elementary/Secondary (0-12): 8th

College (1-4or 5+):

16e. Decedent's Usual Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Home Repair

16b. Kind of Business/Industry: Self Employed

17. Fether's Name *(First, Middle, Last)*: James Young

18. Mother's Name *(First, Middle, Malden Sumema)*: Ossie Burgess

19a. Informant's Name/Relationship *(Type, Print)*: Phyllis Burgess/wife

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 4651 Pimlico Rd. Balto., MD 21215

20e. Method of Disposition: 1 XX Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Neme of cemetery, crematory or other place)*: King Memorial Pk

Date: 12/12

20c. Location - City or Town, Stete: Randallstown, MD

21. Signeture of Funeral Service Licensee: James A. Morton

22. Name and Address of Fecility: James A. Morton & Sons Funeral Home 1701 Laurens St. Balto., MD 21217

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiratory arrast, shock, or Heert failure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Deeth

Immediate Ceuse (Finel disease or condition resulting in deeth)

e. Lung Cancer ; Stage 4

Due to (or es e consequence of):

Sequentially list conditions, if eny, leading to immadiate cause. Enter Underlying Cause (Disease or Injury that Initieted events resulting in death) Last

b.

Due to (or es e consequence of):

c.

Dua to (or as a consaquanca of):

d.

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Part I.

23b. Did tobecco use contribute to the ceuse of death? 1 XX Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24e. Wes en eutopsy performed? 1 ☐ Yes 2 XX No

24b. Were eutopsy findings available prior to completion of ceuse of deeth? 1 ☐ Yes 2 XX No

25. Wes case referred to medical examiner? 1 ☐ Yas 2 XX No

26. Piece of Death *(Check only one)*

Hospitel: 1 XX Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA

Other: 4 ☐ Nursing Hema 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Deeth: 1 XX Naturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending invastigation 6 ☐ Could not be determined

28e. Dete of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1 XX **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es stated. 2 ☐ **Medical Examiner**: On the besis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier: Keith Lee MD

29c. Licanse number: P11767

29d. Data signed *(Month, Day, Year)*: December 6, 1998

30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print): Keith Lee 22 South Greene St Baltimae, MD 21201

State Registrar

31. Dete filed *(Month, Day, Year)*: DEC 08 1998

32. Registrer's Signeture: [illegible] A. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet tha death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending Physician end completely filled in by the funeral director, page 2 should be datached for use at the burial-transit

5

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 37488

Certificate of Death

Item#20b per FH G766 12/08/98 EW

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Data of Death Month / Day / Year	3. Time of Death
HENRY		BAUER	December 3, 1998	02:20 p.m.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Johns Hopkins Hospital	Baltimore	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Data of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-56-8038	1☒ M 2☐ F	48 Yrs.			Sept. 22, 1950	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Baltimore, County	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6903 Beech Avenue	21206	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12 yrs.	N/A	Plumber	C. & H. Mechanical Corporation

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Edward John Bauer	Alverta J. Moll

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Ann Marie Bauer	6903 Beech Avenue Baltimore, Md. 21206

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other (Specify)	PARKWOOD ~~Gardens of Faith~~ Cem.	12-7-98	Baltimore, Md.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
William A Cook	Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. SEPSIS	12 HOURS
Due to (or as a consequence of):	b. ISCHEMIC BOWEL	24 HOURS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. ATHEROSCLEROSIS	7 YEARS
Due to (or as a consequence of):	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CARDIOMYOPATHY

DIABETES MELLITUS

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☑ No	1☐ Yes 2☐ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28l. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
MD	RES-000	DECEMBER 3 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OLIVER BACON TOWER 110 JOHNS HOPKINS HOSPITAL 600 NORTH WOLFE STREET BALTIMORE MARYLAND

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 08 1998	G. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37409

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mildred Gertrude Chenoweth

2. Date of Death (Month, Day, Year): Nov. 30, 1998

3. Time of Death: 4:20 AM

4a. Facility Name *(If not institution, give street and number)*: 20607 Old York Rd.

4b. City, Town, or Location of Death: White Hall

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 218-68-6206

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 87 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Dec. 6, 1910

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residance of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: White Hall

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 20607 Old York Road

10f. Zip Code: 21161

10g. Citizen of What Country?: U.S.A.

11. Maritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Rece - Amarican Indian, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grada completed)*: Elementary/Secondery (0-12): 7 / College (1-4or 5+):

16a. Decedent's Usuel Occupetion *(Giva kind of work dona during most of working lifa. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Fathar's Nama *(First, Middla, Last)*: John A. Kempske

18. Mother's Nema *(First, Middla, Meidan Sumama)*: Mamie Hoffman

19a. Informent's Neme/Ralationship *(Type, Print)*: Vernon H. Chenoweth/Son

19b. Meiling Address *(Street end Number or Rural Routa Number, City or Town, Stete, Zip Code)*: 20607 Old York Rd., White Hall, MD 21161

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Ramoval from Stete 4☐ Donetion 5☐ Other *(Specify)*

20b. Placa of Disposition *(Neme of cemetery, cremetory or othar piece)*: West Liberty Cemetery — Date: Dec. 3, 1998

20c. Location - City or Town, Stete: White Hall, MD

21. Signature of Funeral Service Licensee: J. Hartenstein

22. Name end Address of Feciliity: J.J. Hartenstein Mortuary, Inc. 24 Second St., New Freedom, PA 17349

Physician /Medical Examiner

23a. Part I. Entar tha diseasa, or complications thet caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart feliure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Death

Immediete Causa (Finel disaasa or condition resulting in deeth)

e. Congestive Cardiomyopathy — Approximate Interval: Unknown

Due to (or es e consequance of):

Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury thet Initieted avents resulting in deeth) Last

b. Due to (or es a consequence of):

c. Due to (or as a consequanca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performed? 1☐ Yas 2☒ No

24b. Were autopsy findings eveilabla prior to completion of cause of deeth? N/A 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yas 2☒ No

26. Piece of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Panding investigetion 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Tima of Injury

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, offica building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, deta and placa, end dua to the ceuse(s) and menner es steted. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end placa, end due to the cause(s) end manner stated.

29b. Signature and title of certifier: Stephen G. Sniddores

29c. Licansa number: #40583

29d. Date signed *(Month, Day, Year)*: 12/2/98

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print): Stephen G. Sniddores DO 2081B Emmorton Rd Ste 114 Bel Air Md 21015

State Registrar

31. Dete filed *(Month, Dey, Year)*: DEC 08 1998

32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37490

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Vivian Almira Cusick
2. Dete of Deeth (Month, Day, Year): December 4, 1998
3. Time of Death: 4:23pm
4e. Fecility Name (If not institution, give street end number): 345 Cokeland South
4b. City, Town, or Location of Death: Laurel
4c. County of Deeth: Anne Arundel

Funeral Director

5. Social Security Number: 461-50-5258
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. lest birthday): 89 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Year): Jan. 03, 1909
9. Birthplece (Stete or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: MD
10b. County: Prince George
10c. City, Town or Location: Laurel
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street end Number: 7700 Cherry Lane
10f. Zip Code: 20707
10g. Citizen of Whet Country?: United States

11. Maritel Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): Ø
16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Fether's Neme (First, Middle, Lest): Lehman Hauger
18. Mother's Name (First, Middle, Maiden Surname): Hermie Lash

19a. Informant's Name/Relationship (Type, Print): Johanna Beall, Daughter
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 345 Cokeland South Laurel, Maryland 20724

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other place): Meadowridge Memorial Pk.
Dete: 12/7
20c. Location - City or Town, State: Elkridge, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Fleck Funeral Home, Inc. 7601 Sandy Spring Road Laurel, Maryland 20707

Physician /Medical Examiner

23a. Part I. Enter the disease, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on eech line.

		Approximate Interval Between Onset end Death
Immediate Cause (Final disease or condition resulting in death) a.	Cerebral Vascular Accident	1 week
Due to (or as e consequence of): b.	Cerebrovascular Disease	2 mos.
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest — Due to (or es e consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other elgnificent conditions** contributing to death but not resulting in the underlying cause given in Part I.: Chronic Atrial Fibrillation, Alzheimers Disease

23b. **Did tobecco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was en eutopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 1☐ Yes 2☒ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No
26. Plece of Deeth (Check only one): Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Daughter's Home

27. Menner of Death: 1☒ Netural 2☐ Accident 3☐ Sulcide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Dey Yeer)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Phyelcian:** To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end placa, end due to the ceuse(s) end menner stated.

29b. Signeture end title of certifier: [signature] Russell A. DeLucy M.D.
29c. License number: 037551
29d. Date signed (Month, Dey, Year): December 7, 1998

30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print): Russell A. DeLucy M.D. 1600 S. Crain Highway, Glen Burnie, Md 21061

State Registrar

31. Date filed (Month, Dey, Year): DEC 08 1998
32. Registrer's Signeture: [signature] B. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

10

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37491

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: VERNICE CAMPBELL
2. Date of Death — Month: DEC Day: 3RD Year: 1998
3. Time of Death: 5:30 PM
4a. Facility Name *(If not institution, give street and number)*: GOOD SAMARITAN HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213-32-9380
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 63 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 8-14-1935
9. Birthplace *(State or Foreign Country)*: S.C.

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTO.
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 123 W. 29TH STREET APT.15D
10f. Zip Code: 21218
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* AFR. AMERICAN

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4 or 5+): 0
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOUSEWIFE
16b. Kind of Business/Industry: DOMESTIC

17. Father's Name *(First, Middle, Last)*: JAMES PRICE SR.
18. Mother's Name *(First, Middle, Maiden Surname)*: BESSIE M. PRICE

19a. Informant's Name/Relationship *(Type, Print)*: QUESTER CAMPBELL (SON)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1243 E. BELVEDERE AVE. BALTO. MD 21239

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: WOODLAWN CEMETERY — Date: DEC. 8, 1998
20c. Location - City or Town, State: BALTO. MD

21. Signature of Funeral Service Licensee: CECIL A ESTEP — Cecil A Estep
22. Name and Address of Facility: ESTEP BROTHERS FUNERAL SERVICE P.A. 1300 EUTAW PLACE BALTO. MD 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. BILATERAL MASSIVE STROKE — 1 WEEK

Due to (or as a consequence of):
b. MASSIVE INFERIOR MYOCARDIAL INFARCTION — 1 WEEK

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
HYPERTENSION
DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Ayman Koteish, MD
29c. License number: P10583
29d. Date signed *(Month, Day, Year)*: DEC. 3RD 1998
30. Name and address of person who completed cause of death (Item 23e) (Type, Print): AYMAN KOTEISH, MD - GOOD SAMARITAN HOSPITAL - 5601 LOCK RAVEN BLVD BALTIMORE MD 21239

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 08 1998
32. Registrar's Signature: Geneva G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Item 1 PER PHY FilmG766 12-9-98 rja

State of Maryland / Department of Health and Mental Hygiene 98 37492

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Debora ~~Deborah~~ Annette Cook

2. Deta of Death: Month Nov. Dey 20 Yeer 1998

3. Time of Deeth: 5:50 pm

4e. Facility Name (If not institution, giva street and number): Ravenwood Nursing and Rehab. Center

4b. City, Town, or Location of Deeth: Baltimore

4c. County of Deeth: N/A

Funeral Director

5. Social Security Number: 216-74-8398

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 42 Yrs. | If Undar 1 Yaer: Months / Days | If Undar 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Dey, Yeer): Jan. 24, 1956

9. Birthplaca (Stata or Foraign Country): Maryland

To Be Completed by Funeral Director

Usual Residenca of Decedent

10a. Stata: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Insida City Limits: 1☒Yes 2☐No

10e. Street end Number: 5018 Dicky Hill Road #C7

10f. Zip Code: 21207

10g. Citizen of What Country? USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forcas? 1☐Yas 2☒No If Yes, Giva Yeer or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Bleck, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 11th grade; Collega (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work dona during most of working life, DO NOT use retired): Custodian

16b. Kind of Business/Industry: Baltimore County Public Schools

17. Fether's Nema (First, Middla, Last): Nathan Cook

18. Mother's Name (First, Middla, Maidan Surnema): Carita Lee

19a. Informent's Name/Reletionship (Type, Print): Tisha Taylor / Daughter

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 5018 Dicky Hill Road #C7 Baltimore, Md 21207

20a. Method of Disposition: ☒1 Burial 2☐Cremetion 3☐Ramoval from State 4☐Donetion 5☐Other (Specify)

20b. Place of Disposition (Nema of cemetery, cremetory or othar place): Mt. Auburn Cemetery

Date: 12/28/91

20c. Locetion - City or Town, Stete: Baltimore, Maryland

21. Signature of Funaral Service Licensee: Jerry Lewis

22. Name end Address of Facility: Chatman - Davis F.H. 5240 Reisterstown Road Baltimore, Md 21215

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complicetions that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heert feilure. List only ona ceuse on eech line.

Approximete Intervei Between Onset end Death

Immediete Ceusa (Final diseasa or condition resulting in death): e. Acquired Immune Deficiency 10yrs

Due to (or es e consequence of):

Sequentielly list conditions, if any, leading to immedieta cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in daath) Last

b.

Due to (or es a consequance of):

c.

Dua to (or as a consaquance of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Malnutrition

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Wes en eutopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings availeble prior to complation of cause of deeth? 1☐Yes 2☐No

25. Wes case referred to medical examiner? 1☐Yas 2☒No

26. Piece of Death (Check only one): Hospitel: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Mennef of Death: 1☒Naturel 2☐Accidant 3☐Suicide 4☐Homicide 5☐Pending invastigetion 6☐Could not be determined

28e. Dete of injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, streat, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifiar (Check only one): 1☒Certifying Physician: To the best of my knowledga, death occurred et the time, deta and piace, and dua to the cause(s) end mannar as stated. 2☐Medical Examiner: On the basis of examination and/or investigetion, in my opinion, daeth occurred at the time, date end pleca, and dua to tha causa(s) end manner steted.

29b. Signatura and title of certifiar: Christie Lamping

29c. License number: D32263

29d. Date signed (Month, Day, Year): 12/4/98

30. Nama and eddress of person who complated cause of death (Item 23a) (Type, Print): CHRISTIE LAMPING 2000 W Baltimore 21223

State Registrar

31. Date filed (Month, Day, Year): DEC 08 1998

32. Registrer's Signature: James G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37493

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): GLADYS A. CASNER
2. Date of Deeth — Month / Dey / Year: December 4, 1998
3. Time of Deeth: 6:40 PM
4a. Fecility Neme (If not institution, give street and number): Lorien Nursing Home
4b. City, Town, or Location of Deeth: Columbia
4c. County of Deeth: Howard

Funeral Director

5. Social Security Number: 165-09-1250
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. lest birthday): 86 Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Year): June 18, 1912
9. Birthplece (State or Foreign Country): Allentown, PA

Usuel Residence of Decedent

10a. Stete: MD
10b. County: Howard
10c. City, Town or Location: Columbia, Maryland
10d. Inside City Limits: ☒ Yes 2☐ No
10e. Street end Number: 6334 Cedar Lane
10f. Zip Code: 21044
10g. Citizen of Whet Country?: United States

11. Maritat Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Yeer or Detes:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed): Elementary/Secondery (0-12): 12 — College (1-4or 5+): 0
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Telephone Operator
16b. Kind of Business/Industry: Communication

17. Father's Neme (First, Middle, Last): Ralph H. Zinszer
18. Mother's Name (First, Middle, Maiden Surneme): Bertha May Wolf

19a. Informent's Name/Relationship (Type, Print): Paul Casner, Jr. / Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 12268 Woodspurge Court, Ellicott City MD 21042

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Glenwood Memorial Gardens — Dete: December 8, 1998
20c. Locetion - City or Town, State: Broomall, PA

21. Signeture of Funeral Service Licensee: Victor P. Doda, Jr. — Victor P. Doda, Jr.
22. Neme end Address of Fecility: Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore MD 21230

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complicetions that caused the deeth. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heert failure. List only one cause on eech line. — Approximete Intervel Between Onset end Death

Immediate Ceuse (Finel diseese or condition resulting in deeth)
a. Alzheimers Disease — Years
Due to (or es e consequence of):
Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury thet initiated events resulting in deeth) Lest
b.
Due to (or es e consequence of):
c.
Due to (or as e consequence of):
d.

Pert II. **Other signficant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco uee contribute to the cauee of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings eveilable prior to complation of ceuse of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical exeminer? 1☐ Yes 2☒ No
26. Place of Deeth (Chack only one): Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Mennar of Deeth: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Coutd not be determined
28a. Place of Injury - At home, farm, streat, factory, office building, etc. (Specify)
28b. Time of injury
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Deecribe how injury occurred
28e. Date of Injury (Month, Dey Year)
28f. Location (Streat and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Phyeician:** To the best of my knowledge, deeth occurred et the time, deta and place, end due to the causa(s) and menner es steted. 2☐ **Medical Examiner:** On the besis of examination end/or Investigation, in my opinion, death occurred et the time, deta end place, end due to the ceuse(s) end menner steted.

29b. Signeture and title of certifier: [signature]
29c. License number: D22856
29d. Date signed (Month, Day, Year): December 5, 1998

30. Neme and eddress of person who completed ceusa of deeth (Item 23e) (Type, Print): Jerry I. Levine, MD, 11055 Little Bennett Pky, Columbia, Md 21044

State Registrar

31. Date filed (Month, Day, Year): DEC 08 1998
32. Registrar's Signeture: Benna B. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37494

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Leila R. Carroll
2. Date of Death (Month, Day, Year): DEC 05, 1998
3. Time of Death: 11:10AM
4a. Facility Name *(If not institution, give street and number)*: Mariner North Arundel Nursing Home
4b. City, Town, or Location of Death: Glen Burnie
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 439-96-1509
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 95 Yrs. (If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.)
8. Date of Birth *(Month, Day, Year)*: JAN 07, 1903
9. Birthplace *(State or Foreign Country)*: Louisiana

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Linthicum
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 551 First Street
10f. Zip Code: 21090
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 9; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Oren Robinson
18. Mother's Name *(First, Middle, Maiden Surname)*: Leila Gay Life

19a. Informant's Name/Relationship *(Type, Print)*: Gay Bruce/Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 551 First Street Linthicum, MD 21090

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metro Crematory, Inc.
Date: 12/06/98
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Edward A. Gregorchik
22. Name and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Respiratory Failure
Due to (or as a consequence of): b. Emphysema
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of): c.
Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: dehydration; senile dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and piece, end due to the cause(s) and manner stated.
29b. Signatura and title of certifier: Reagan
29c. License number: 031344
29d. Data signed *(Month, Day, Year)*: 12/5/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Bradley Gaigns 716 Maiden Choice Ln, Catonsville MD 21228

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 08 1998
32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funerel director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

4 pgs

ADH
98-6968-510
CHARLES COOK

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEMS: #23 PART I, II, 27, 28A-F PER G766 12-16-98 WR

Certificate of Death

Reg. No. 98 37495

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last): Charles Edward Cook				2. Date of Death (Month, Day, Year): DECEMBER 1, 1998	3. Time of Death: 0855 AM
4a. Facility Name (If not institution, give street and number): 1700 ST. PAUL STREET , # 302		4b. City, Town, or Location of Death: BALTIMORE CITY		4c. County of Death: N/A	
5. Social Security Number: 212-46-2168	6. Sex: 1☒ M 2☐ F	7. Age (In yrs. last birthday): 52 Yrs.	If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year): OCT 25, 1946	9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	N/A	Baltimore	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1700 St. Paul Street, # 302	21202	USA

11. Marital Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indien, Black, White, etc.
1☐ Never Married 2☐ Merried 3☐ Widowed 4☒ Divorced	1☒ Yes 2☐ No If Yes, Give Year or Detes: Vietnam	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Medical Office Technician	Radiology

17. Father's Name (First, Middle, Last)	18. Mother's Neme (First, Middle, Maiden Surname)
William Kenneth Cook	Nellie May White

19a. Informant's Name/Relationship (Type, Print)	19b. Meiting Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code)
Kelly M. Cook / daughter	3290 N.E. 5th Drive Boca Raton, FL 33431

20a. Method of Disposition	20b. Place of Disposition (Neme of cemetery, cremetory or other piece)	Date	20c. Location - City or Town, Stete
1☐ Burial 2☒ Cremetion 3☐ Removel from State 4☐ Donation 5☐ Other (Specify)	Metro Crematory, Inc.	12/05/98	Baltimore, MD

21. Signature of Funeral Service Licensee: George E. MacNabb

22. Name end Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart feilure. List only one cause on each line.

Approximete Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death)
a. ACUTE NARCOTIC INTOXICATION
Due to (or es e consequence of):

Sequentially tist conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last
b.
Due to (or es a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CIRRHOSIS OF LIVER

CHRONIC ALCOHOLISM

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performed?	24b. Were eutopsy findings eveilable prior to completion of cause of death?
1☒ Yes 2☐ No	1☒ Yes 2☐ No

25. Wes case referred to medical examiner?	26. Place of Death (Check only one)	
1☒ Yes 2☐ No	Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☒ Could not be determined	Found: 12-1-98	Found: 8:50 A M	1☐ Yes 2☒ No	UNKNOWN

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify): FOUND AT HOME

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete): 1700 ST. PAUL ST. #302 BALTIMORE, MARYLAND

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) and menner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)
Dennis J Chute MD	OCME	DECEMBER 1, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dennis J Chute, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 08 1998	Barbara G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37496

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): RUBY I. CHADWELL

2. Date of Death Month Day Year: NOVEMBER 30, 1998

3. Time of Death: 5:45PM

4a. Facility Name (If not institution, give street and number): Spa Creek Genesis

4b. City, Town, or Location of Death: ANNAPOLIS

4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 218-22-8047

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 81 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): OCT. 10, 1917

9. Birthplace (State or Foreign Country): Tennessee

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Edgewood

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 450 Flying Point Road

10f. Zip Code: 21040

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+): N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Daniel Terry

18. Mother's Name (First, Middle, Maiden Surname): Doll Gross

19a. Informant's Name/Relationship (Type, Print): Raymond Chadwell Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 357 San Gria Ct. Pasadena, Maryland 21122

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Greenmount Cemetery

Date: Dec. 3, 1998

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: John F. Collins

22. Name and Address of Facility: McCully-Polyniak Funeral Home 3204 Mountain Road Pasadena, Maryland 21122

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Pneumonia — 1 on

Due to (or as a consequence of): Pneumothorax — 1M

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

Division of Vital Records, P.O. Box 68760,

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D32036

29d. Date signed (Month, Day, Year): 12/2/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Gary J. Sprouse 2108 D. Donald Drive Chesterton MD 21619

State Registrar

31. Date filed (Month, Day, Year): DEC 08 1998

32. Registrar's Signature: Denise G. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37497

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Harold Cumberland Calvert
2. Date of Death Month Dey Yeer: Dec. 2, 1998
3. Time of Death: 1:05 P.M.
4e. Facility Name *(If not institution, give street and number)*: Genesis Eldercare at Hammonds Lane
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 215-07-7808
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 83 Yrs. — If Under 1 Year: Months / Deys; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Dey, Year)*: May 24, 1915
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. Stete: Md.
10b. County: Anne Arundel
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street end Number: 301 Twelth Avenue
10f. Zip Code: 21225
10g. Citizen of Whet Country?: U.S.A.

11. Merital Status: 1 [ ] Never Merried 2 [X] Merried 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Yeer or Dates: WWII
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indien, Bleck, White, etc. *Specify:* White
15. Decedent's Educetion *(Specify only highest grede completed)*: Elementery/Secondary (0-12): 12th — College (1-4or 5+): 0
16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Supervisor
16b. Kind of Business/Industry: S C M Corp.
17. Fether's Neme *(First, Middle, Last)*: George W. Calvert
18. Mother's Neme *(First, Middle, Meiden Surneme)*: Carrie Elizabeth Cumberland
19a. Informent's Neme/Reletionship *(Type, Print)*: Ethel M. Calvert (Wife)
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 301 Twelth Avenue Baltimore, Maryland 21225
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removel from Stete 4 [ ] Donetion 5 [ ] Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, crematory or other piece)*: Cedar Hill Cemetery — Dete: 12/7/98
20c. Location - City or Town, Stete: Baltimore, Maryland
21. Signature of Funeral Service Licensee: Kevin E. Ecker
22. Neme end Address of Facility: McCully-Polyniak Funeral Home, 237 E. Patapsco Avenue Baltimore, Maryland 21225

Physician /Medical Examiner

23a. Pert I. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. — Approximete Interval Between Onset end Deeth

Immediate Ceuse (Final disease or condition resulting in deeth)
e. Aspiration Pneumonia — one week
Due to (or es e consequence of):
b. Parkinson's Disease
Sequentielly list conditions, if eny, leading to immediete ceuse. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Lest
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Pert II. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Pert I.
Hypertension
Cerebrovascular Thromboses

23b. Did tobacco use contribute to the ceuse of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown
24e. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No
24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? 1 [ ] Yes 2 [X] No
25. Was cese referred to medicel examiner? 1 [ ] Yes 2 [X] No
26. Piece of Deeth *(Check only one)*: Hospitel: 1 [ ] Inpetient 2 [ ] ER/Outpetient 3 [ ] DOA — Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*
27. Manner of Deeth: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined
28a. Dete of Injury *(Month, Dey Yeer)*
28b. Time of Injury M
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Phyeician:** To the best of my knowledge, death occurred et the time, date end piece, end due to the ceuse(s) end manner es steted. 2 [ ] **Medicel Examiner:** On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) end manner stated.
29b. Signature end title of certifier: ▶ Colvin C. Carter, M.D.
29c. License number: DO 1459
29d. Date signed *(Month, Day, Year)*: Dec. 4, 1998
30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): Colvin C. Carter 4710 Pennington Avenue Baltimore, Maryland 21226

State Registrar

31. Date filed *(Month, Dey, Yeer)*: DEC 08 1998
32. Registrer's Signeture: ▶ D. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

6+1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 90 37498

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: HELEN A. CAREY
2. Date of Death Month Day Year: 12 - 05 - 1998
3. Time of Death: 730 AM

4a. Facility Name *(If not institution, give street and number)*: 400 GREENLAND BEACH DRIVE
4b. City, Town, or Location of Death: PASADENA
4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 218 01 4467
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 82 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: March 9, 1916
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10e. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 400 Greenland Beach Road
10f. Zip Code: 21226
10g. Citizen of Whet Country?: U.S.

11. Marital Stetus: 1☐ Nevar Marriad 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedant Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Datas:
13. Was Dacedant of Hispenic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th — College (1-4or 5+):
16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retirad)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Fether's Name *(First, Middle, Last)*: Julius Houff
18. Mother's Name *(First, Middla, Meidan Surneme)*: Helen Walter

19a. Informant's Name/Reletionship *(Type, Print)*: Dolores Rush / daughter
19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 8236 Ft. Smallwood Road Baltimore, Maryland 21226

20e. Method of Disposition: 1☐ Burial 2☒ Cramation 3☐ Removal from Stata 4☐ Donetion 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or othar placa)*: Hilltop Service Corp.
Date: 12/8/98
20c. Location - City or Town, Stata: Towson, Maryland

21. Signature of Funeral Service Licensee: Richard E. Davis
22. Neme end Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the daath. Do not entar the mode of dying, such as cardiac or raspiratory errest, shock, or heart failure. List only one ceuse on eech line. — Approximate Intervel Between Onset end Deeth

Immedlete Ceuse (Final disease or condition resulting in death)
e. Chronic atrial fibrillation
Due to (or as a consequence of):
b. ischemic Heart disease
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events rasulting in deeth) Last
Due to (or es e consequence of):
c. Hypertensive ARTERIOSCLEROTIC CARDIOVASULAR Disease
Dua to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
- Severe Rheumatoid ARTHRITIS
- pulmonary fibrosis with Chronic obstructive pulmonary Disease
- MITRAL INSUFFICIENCY

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Was en autopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☒ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No
26. Piece of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Deeth: 1☒ Naturel 2☐ Accident 3☐ Sulcide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28e. Date of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Streat end Number or Rurel Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner as stated. 2☐ **Medical Examiner:** On the besis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end menner steted.
29b. Signature and title of certifier: Ana Maria Martinez
29c. License number: D37229
29d. Date signed *(Month, Day, Year)*: 12-06-1998
30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print): ANA MARIA MARTINEZ, M.D. 2932-A MOUNTAIN ROAD PASADENA MARYLAND 21122-2014

State Registrar

31. Dete filed *(Month, Day, Year)*: DEC 08 1998
32. Registrar's Signature: Steve B. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

6

Amend: #1 Per MD,#14,18 Per Informant Film G766 12-24-98RC

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend: #24a Per MD Film G766 12-8-98RC

Certificate of Death

Reg. No. 98 37499

CHIN, JOHN

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ~~John Chin~~ JOHN YOOK HONG CHIN

2. Date of Death (Month, Day, Year): NOVEMBER 18 1998

3. Time of Death: 1:20 PM

4a. Facility Name (If not institution, give street and number): HARBOR HOSPITAL CENTER

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216 32 9817

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 73 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 29, 1925

9. Birthplace (State or Foreign Country): China

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 4146 Doris Avenue

10f. Zip Code: 21225

10g. Citizen of What Country?: U.S.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: ~~White~~ ASIAN

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Self Employed

16b. Kind of Business/Industry: Laundry

17. Father's Name (First, Middle, Last): DeBin Chin

18. Mother's Name (First, Middle, Maiden Surname): ~~Gim Chun Toy~~ KAM CHEUN CHOI

19a. Informant's Name/Relationship (Type, Print): Raymond Chin / son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 16004 Howard Landing Drive Gaithersburg, Md. 20878

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Cedar Hill Cemetery

Date: 11/23/98

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Jerome Gonce

22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. SEPSIS — 2 DAYS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end manner es stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: INTERN

29c. License number: P 12797

29d. Date signed (Month, Day, Year): NOVEMBER 18 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SHWE MRA GYAW 3001 SOUTH BALTIMORE ST. BALTIMORE MD 21225

State Registrar

31. Date filed (Month, Day, Year): DEC 08 1998

32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 37500

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CARLISLE DUVALL
2. Date of Death Month Day Year: DECEMBER 03, 1998
3. Time of Death: 4:15 AM

4a. Facility Name (If not institution, give street and number): Northwest Medical Center
4b. City, Town, or Location of Death: Randallstown
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 217-16-0027
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 11, 1920
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decadent

10a. State: MD
10b. County: Carroll
10c. City, Town or Location: Sykesville
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 167 Klees Mill Rd.
10f. Zip Code: 21784
10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed): Elementery/Secondary (0-12): 7 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Carpenter
16b. Kind of Business/Industry: Self Employed

17. Father's Neme (First, Middle, Last): Walter Duvall
18. Mother's Neme (First, Middle, Maiden Surneme): Unknown

19a. Informant's Name/Relationship (Type, Print): Walter R. Humple, Brother in Law
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code): 167 Klees Mill Rd., Sykesville, Md. 21784

20e. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other place): Mt. Paren Cemetery
Date: 12/7/98
20c. Location - City or Town, State: Randallstown, Md.
21. Signature of Funeral Service Licensee: [signature]
22. Name end Address of Facility: 11824 Reisterstown Rd. Eline Funeral Home Reisterstown, Md. 21136

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death

Immediete Ceuse (Final disease or condition resulting in death): e. Respiratory Failure
Due to (or es e consequence of): Pneumonia
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Last:
b. Due to (or es e consequence of):
c. Due to (or as e consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: DM II ; Schizophrenia ; UTI

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown
24e. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were eutopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical exeminer? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Naturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Piece of injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) and manner es steted. 2 [ ] **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and menner stated.
29b. Signeture end title of certifier: [signature] MD
29c. License number: D44508
29d. Date signed (Month, Day, Year): December 8, 1998
30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): A.J. IMPERIAL, JR — NWHC.

State Registrar

31. Date filed (Month, Dey, Yeer): DEC 08 1998
32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial transit permit.

6x1

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